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ABSTRACT

This report presents school- and community-based mental health programs in which school psychologists were engaged in program development, implementation, and/or evaluation. Exemplary programs were identified using five standards of activity, such as the integration of theory, research, and practice. To identify the programs, surveys were mailed to 195 programs in 44 states. Completed surveys were received from 87 programs, and of these, 32 met all criteria for exemplary programs. Details on program demographics, program staff, funding, the school psychologist's role, the program model, and program descriptions are outlined. Programs are listed by state and include such information as the program name, the supervising person, a description of the program, the program goals, and steps to program implementation. Details are also provided on program evaluations, available written materials, and exemplary characteristics--grouped under the categories of school psychologist's program involvement, ecological-collaborative model, theoretical base, empirical base, program evaluation, and levels of service provision. Contains approximately 135 references. (RJM)

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Exemplary Mental Health Programs: School Psychologists As Mental Health Service Providers

NATIONAL
ASSOCIATION OF
SCHOOL
PSYCHOLOGISTS

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EXEMPLARY MENTAL HEALTH PROGRAMS: SCHOOL PSYCHOLOGISTS AS MENTAL HEALTH SERVICE PROVIDERS

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LITERATURE REVIEW

Statistics regarding mental health concerns of children and youth provide strong support for mental health programming in schools. It has been estimated that 15 to 22% of children and adolescents have mental health problems severe enough to warrant psychological treatment (National Advisory Mental Health Council, 1990; Zill & Schoenborn, 1990). The number of adolescent suicides has increased by 300% during the past 30 years, and suicide has become the third leading cause of death among 15 to 24 year olds and the fourth leading cause of death among 5 to 14 year olds (Malley, Kush, & Bogo, 1994).

Children and adolescents are frequently faced with personal and environmental stressors that put them at risk for emotional, behavioral, and academic difficulties. Crises that are common for the school-aged population include violence, death/suicide, parental divorce and/or remarriage, child maltreatment, developmental transitions (e.g., puberty) and educational transitions (e.g., entry into high school; transition to or from special education programs) (Pitchner & Poland, 1992; Saigh, Green, & Korol, 1996; Sandoval, 1985).

The number and severity of crises facing school-aged populations are increasing (National School Safety Center, cited in Pitchner & Poland, 1992). One out of every 16 adolescents is a victim of a violent crime (Soriano, Soriano, & Jimenez, 1994). Children who witness violence are more likely to experience emotional, academic and behavioral problems, including antisocial behavior (Bell & Jenkins, 1991).

Although schools generally are prepared to deal with developmental transitions, they are not typically prepared to address situational crises (Brock, Sandoval & Lewis, 1996). Furthermore, the majority of children with behavioral and emotional problems do not access mental health clinics (Offord, Boyle, Szatmari, Rai-Grant, Links, Cadman, Byles, Crawford, Blum, Byrne, Thomas, & Woodward, 1987). Schools are increasingly viewed as a critical context for providing mental health services to children and adolescents (e.g., Malley, et al., 1994; Howerton & Enger, 1994; Pitchner & Poland, 1992) and school psychologists can play a critical role in the development, implementation, and evaluation of such efforts (e.g., suicide, Sandoval & Brock, 1996; crisis intervention, Brock et al., 1996). Although many schools have attempted to address the mental health needs of children and adolescents through programming and teacher training, the involvement of school psychologists in these efforts is not well documented.

Given the increasing need for school-based mental health services and potential role of school psychologists in service provision, it is critical to examine characteristics of exemplary programs and the role played by school psychologists in providing such programs. The purpose of this project was to identify and document exemplary school/community-based mental health programs in which school psychologists were engaged in one or more aspects of program development.

We conducted an extensive literature review of mental health programming in order to document the current empirical base regarding effective programming, identify exemplary characteristics, and examine the role of the school psychologist in providing mental health services. We examined programming across the continuum of service provision from prevention to treatment, specifically in the areas of social skills development, substance abuse prevention, suicide prevention, violence prevention, sexual abuse prevention, crisis intervention, counseling, and treatment of children with emotional/behavioral disorders.

Conceptual Model of Mental Health Programming

The conceptual model that guided identification and evaluation of exemplary programs included five components, that reflect current best practices in program development. To this list, we added a sixth criterion, specific to the interests of the National Association of School Psychologists (NASP). The six components include the following (see Table 1).

1. Programming reflects an integration of theory, research, and practice.
2. Programming is framed within an ecological-developmental theoretical model.
3. Program development, implementation, and evaluation reflect a collaborative/participatory model.
4. A continuum of mental health services are provided, ranging from prevention to treatment.
5. Program evaluation addresses program acceptability, integrity, and effectiveness.
6. School psychologist involvement in one or more aspects of mental health programming.

In this section, we describe each of the components and review literature on programming that exemplifies the target criteria for mental health programming.

Table 1. *Exemplary Criteria For Mental Health Programming*

* Theory-research-practice integration

* Ecological-developmental model

* Collaborative-participatory model

* Continuum of mental health services

* Evaluates program acceptability, integrity, efficacy

*School psychologist involvement

Integration of Theory, Research, and Practice

Mental health programming that is guided by theory and research is consistent with the well-accepted conceptualization of the school psychologist as scientist-practitioner and with the concept of *praxis* (Partridge, 1985) that has been applied to other social science fields (e.g., applied anthropology; S. L. Schensul, 1985). Praxis refers to the continual interplay of theory, research and practice (cf. Partridge) that characterizes reflective practice and action research. S. L. Schensul describes this theory-research-action/practice paradigm as follows: Theory guides the generation of research questions or hypotheses and subsequent data collection. The data inform theory and the construction of interventions (action/practice). The outcome of interventions are documented through data collection (research), and then inform theory, which subsequently informs intervention design or modification, and so on. In this way, theory and research provide the basis for interventions, the implementation and evaluation of which subsequently inform theory and future research. Thus, theory, research and practice continually interact to guide applied social science in general and mental health programming more specifically.

Optimally, praxis or action research is collaborative in nature, involving interdisciplinary collaboration of researchers and practitioners in applied settings (e.g., teachers and school psychologists in classrooms). A collaborative action research approach (cf. J. J. Schensul, 1985) is likely not only to enhance the integration of theory, research, and practice, but also to foster communication and dissemination of research through ongoing interactions of school psychologists with practitioners and participants (e.g., students, parents, community members). In addition, such activity is likely to foster research that addresses real-life issues and thus enhances the relevance and application of research findings. Furthermore, this model of the scientist-practitioner holds promise for integrating the seemingly disparate roles of school psychologists. That is, an action research model provides the framework for integrating assessment, intervention, consultation, and research. Ideally, this integration also fosters engagement in and dissemination of research by practitioners.

Meyers and Nastasi (in press) suggest that collaborative action research provides a framework for guiding prevention programming and organizational consultation regarding program development. They provide a case example of its use in developing and implementing prereferral intervention teams in schools. This model also has been applied to the development of substance abuse and sexual risk prevention programs for youth in the U. S. (e.g., Hartford, CT; J. J. Schensul, 1994) and other countries (e.g., Sri Lanka; Nastasi, J. J. Schensul, Sivayoganathan, & Varjas, 1997; Nastasi, S. L. Schensul, & Varjas, 1996). For example, a sexual risk project directed toward Sri Lankan adolescents and young adults involved the following steps: (a) data were collected regarding sexual knowledge, attitudes, and practices of youth within the target community; (b) these data were used to develop a culture-specific intervention; and (c) formative and summative evaluation data were used not only to assess program efficacy but also to inform theory and guide future research within Sri Lanka and internationally.

Although not reflecting an action research approach, much of mental health programming is linked explicitly to existing theory and research. For example, Casey and Berman (1985), in a review of 72 studies of counseling with children, found that 56% of the studies used behavioral treatment, 29% client-centered, 9% dynamic therapy and 9% mixed-therapy model. The Children of Divorce Intervention Program (COPID; Pedro-Carroll & Cowen, 1985) draws from an extensive body of research on children's adjustment to parental divorce as well as efficacy research on specific intervention strategies (Grych & Fincham, 1992). Similarly, the ESCAPE (Enhancing Social Competence and Personal Efficacy) Program, a prevention program developed by Nastasi and DeZolt (1994) to address the needs of children of alcoholics (COAs), draws from research on the characteristics and experiences of COAs as well as efficacy research on social-competence enhancement and substance abuse prevention.

Not all mental health programming is clearly linked to a theoretical-empirical base. For example, one of the limitations of child sexual abuse prevention programming is that programs have been developed with only anecdotal information about the victimization process (Budin & Johnson, 1989). So it is unclear if the program content reflects real-life experiences. It is only in recent years that victims and perpetrators have been surveyed in a systematic manner about the victimization process (e.g., Berliner & Conte, 1990; Kaufman, Harbeck-Weber, & Rudy, 1994). A meta-analysis of 72 studies (conducted from 1952-1983) on counseling with children revealed that 15% of the studies were not classifiable with regard to a theoretical model (Casey & Berman, 1985).

Ecological-Developmental Model

We adopted an ecological-developmental model (Bronfenbrenner, 1989) as the framework for understanding mental health and guiding service provision. An ecological-developmental perspective represents an intersection of person-centered and environment-centered models (e.g., Elias & Branden, 1988). That is, development is viewed as a progressive, mutual accommodation of the individual and the environment. Thus, in order to understand and/or change human behavior, one must attend to the ecological contexts in which the individual is socialized (e.g., school, family, community) as well as the interaction of those contexts (e.g., parent-teacher interaction). Furthermore, the individual plays an active role in development, such that one's personal qualities and behavior engender certain interactions with the environment.

Mental health assessment and intervention require close attention to the dynamic qualities of the person-context interaction within respective contexts and to the interaction between these contexts. [For a more detailed treatment of this topic, see Nastasi & DeZolt, 1994; Meyers & Nastasi, in press.] Attention to ecological systems calls for consideration of cultural factors, thus facilitating culturally-specific interventions. Furthermore, adopting a collaborative/participatory model of program development is consistent with an ecological model of practice.

The literature provides numerous examples of prevention programs which address mental health programming from an ecological perspective. For example, Herbert (1989) describes a school-based program in Fairfax County, Virginia, that was designed to increase suicide awareness and referral within key ecological contexts. Target audiences were school mental health staff, teachers, parents, and students. In Paramount, California, a violence prevention (anti-gang) program, "Alternatives to Gang Membership", was directed toward elementary and intermediate school students, their parents, and community members (Health, Education, and Human Services Division, 1995). This program was one of four identified by the Health, Education, and Human Services Division as "state of the art" in violence prevention programming. Among the seven criteria for identification of promising programs, this Division committee included characteristics consistent with an ecological-developmental model: (a) parental involvement; (b) interagency partnerships and community linkages; and (c) a culturally sensitive and developmentally appropriate approach. Gilchrist, Schinke, Trimble, and Cvetkovich (1987) developed and tested an alcohol and other drug (ATOD) prevention program for Native American youth in the Pacific Northwest. Program developers designed curriculum that reflected culture-specific values and experiences to facilitate cultural sensitivity. In addition, program sessions were co-facilitated by a project staff member and an indigenous professional.

Programs targeting at-risk students were found to reflect an ecological-developmental framework. For example, in addition to targeting children from divorced families, Stolberg and his colleagues (Stolberg, Camplair, Currier, & Wells, 1987; Stolberg & Garrison, 1985) provided intervention for parents as well; thereby, targeting the adjustment of children and parents as well as the parent-child interaction. The focus on parent-child interaction was based on earlier work by Stolberg suggesting that parent-child interaction mediated the relationship between maternal well-being and child adjustment following divorce. This program is also consistent with recommendations by Guidubaldi, Perry, and Nastasi (1987). Based on research regarding the relationship between contextual (school and family) factors and child adjustment following divorce, Guidubaldi and his colleagues suggest that interventions for children of divorce be framed within an ecological model that addresses students, parents, school policies, and interagency collaboration (e.g., school and community coordination of services).

Recent efforts to provide ecologically-based comprehensive services to students with severe emotional and behavioral disorders are exemplified by the California System of Care Model (Attkisson, Dresser, & Rosenblatt, 1995; Attkisson & Rosenblatt, 1993; Jordan & Hernandez, 1990). This model involved collaboration between schools and county mental health agencies in order to coordinate service provision and maintain the students within their school and home communities. As such, the model also exemplifies another exemplary program criterion, the use of a collaborative/participatory model of program development and service provision.

Collaborative/Participatory Model

The use of a collaborative/participatory model for mental health programming is consistent with recent efforts to support team-based approaches to school reform (Adelman, 1995; Curtis & Stollar, 1996), collaborative consultation as a model for indirect service delivery by school psychologists (Rosenfield & Gravois, 1996; Sheridan, Kratochwill, & Bergan, 1996), home-school collaboration (Christenson & Cleary, 1990; Christenson & Conoley, 1992), and participatory models for conducting applied research (J. J. Schensul & S. L. Schensul, 1992). With regard to delivery of mental health services, Adelman (1995) calls for increased school-community collaboration within school reform efforts. Furthermore, he identifies school psychologists as possible organizational facilitators to coordinate collaborative efforts within and between schools; and among schools, community mental health and/or social service agencies, and families. In participatory approaches to research, constituents (researchers, service providers, legislators, community members) work as partners to conduct research, develop community programs, and influence social policy (J. J. Schensul, 1985). Constituent groups include all those who have vested interests and contribute necessary resources. Similarly, in collaborative models of mental health programming, students, parents, teachers, administrators, community members, and mental health professionals participate in program development, implementation, and evaluation (Nastasi & DeZolt, 1994). Such efforts are likely to ensure cultural specificity, empower members of the constituent groups, and facilitate program acceptability and sustainability (i.e., continuation and institutionalization) (Anderson, 1989; Meyers & Nastasi, in press; Nastasi & DeZolt, 1994; J. J. Schensul, 1985).

Continuum of Services

A broad-based model of mental health programming requires a continuum of services ranging from prevention programs for the general population to treatment of individuals with moderate to severe mental health problems (see Table 2; Meyers & Nastasi, in press; Nastasi, 1995). This model represents a modification of the classic Caplanian model for prevention programming (primary, secondary, tertiary levels; Caplan, 1964). As depicted in Table 2, the continuum varies with regard to population, focus and intensity of services, identification procedures, context for service provision, and staffing requirements. The continuum of services incorporates other exemplary program criteria. For example, attention to the ecology is evident in the foci of intervention; that is, both the individual and the environment are targeted. Program implementers include professionals, parents, and paraprofessionals, suggesting a participatory model of service delivery.

The literature on mental health programming reflects this continuum of service provision, ranging from prevention (e.g., social skills development, substance abuse prevention) to risk reduction (e.g., crisis intervention, interventions for children of divorce), to early intervention (e.g., counseling) to treatment of children with emotional/behavioral disorders. Comprehensive programming incorporates the full continuum, as has been suggested in the case of service provision to children of alcoholics (COAs) (Nastasi & DeZolt, 1994; Nastasi, 1995). For example, all students might receive classroom-based preventive intervention focused on alcoholism and its impact on family functioning, as part of a drug abuse prevention curriculum. This educational context then provides opportunities to identify children of alcoholics, based on self-disclosure and/or response to screening measures. Subsequently, identified COAs could be provided the opportunity to participate in small- group intervention focused on adjusting to the difficulties of living with an alcoholic parent. Finally, those individuals who are exhibiting mild to severe adjustment difficulties (including substance abuse) related to family alcoholism can be provided with more intensive interventions within the school context or referred to appropriate treatment facilities. Treatment, particularly within the community context, could address the needs of the child as well as the family.

Table 2. *Continuum of Mental Health Services: Levels of Intervention*

Level	Target Population	Focus	Selection	Context	Staff
I. Prevention (e.g., personal-social goals are integrated into academic curriculum)	General population	Foster individual development; create supportive social environments	All students receive the intervention	Intact group (e.g., classroom)	Teachers, paraprofessionals, peer educators; supported by professional staff
II. Risk reduction (e.g., support groups for children of alcoholics)	High-risk population	Build competence; teach coping skills; modify social context	Self-selection; identification not required	Small group	Mental health staff or paraprofessionals supported by professional staff
III. Early intervention (e.g., counseling group for students experiencing mild depression)	Individuals with mild adjustment problems	Treat mild adjustment problem; reduce risk of more severe problems (see Level II); modify context to effect individual adjustment	Identification through screening/referral	Individual or small group	Mental health staff or paraprofessionals supported by professional staff
IV. Treatment (e.g., therapy for children with severe emotional disturbance)	Individuals with moderate to severe mental health problems	Treat identified mental health problem; modify context to effect individual's functioning	Identification through diagnosis by mental health professional	Individual or small group	Mental health staff

Model of Evaluation

Evaluation is a critical component of programming. Evaluation helps program developers (a) assess the reactions of program recipients (i.e., program acceptability); (b) determine the extent to which the intervention was implemented as designed and identify key program components (program integrity); and (c) evaluate the effectiveness of the intervention (program efficacy). In recent years, school psychologists have become more cognizant of the need for a broad conception of evaluation, focused on program acceptability, integrity, and efficacy (e.g., Elliott , Witt, & Kratochwill, 1991; Nastasi & DeZolt, 1994). This model has been applied to school-based behavioral interventions (Elliott et al., 1991), clinical practice (Kazdin, French, & Sherick, 1981), and prevention programming (Nastasi et al., 1997). Table 3 provides descriptions of the three foci of evaluation and examples of relevant measures (see Nastasi & DeZolt, 1994, for a more detailed discussion).

This model of evaluation fits well with other criteria for exemplary programs. That is, appropriate evaluation facilitates a theory-research-practice approach to mental health programming. In addition, a collaborative/participatory model facilitates program acceptability, implementation with integrity, and program effectiveness. Moreover, within a collaborative model, program developers, implementers and recipients contribute to evaluation activities.

Table 3. *Model of Program Evaluation*

Evaluation Focus	Definition	Examples of techniques
Acceptability	Participants (facilitators and recipients) find program feasible, useful, effective, and consistent with their world views.	Interviews Focus groups Questionnaires Journals
Integrity	Program is implemented as designed. Alternatively, one documents variations in program implementation by different facilitators or with different recipients in order to identify needed modifications in program or staff training.	Activity logs Observations Interviews Self-evaluation measures Journals

Efficacy	Program outcomes; that is, the extent to which the program meets stated goals and objectives, as well as unintended outcomes.	Observation Interviews Self-report measures Ratings by others Analog measures Curriculum-based measures

School Psychologists' Role in Mental Health Programming

For at least the past two decades, school psychologists have been encouraged to extend the nature of the activities in which they are engaged—to "expand" their professional roles—to widen the scope of the traditional assessment role to include consultation, intervention, prevention, and organizational change (Cheramie & Sutter, 1993; Knoff & Curtis, 1996; Reschly, 1988). In particular, practitioners have been encouraged to increase their involvement as mental health service providers—as prevention specialists who help teachers and school administrators foster the development of competent (i.e., mentally healthy) individuals (Elias & Branden, 1988); as providers of services at primary, secondary and tertiary levels (Sandoval & Brock, 1996); as child advocates who assist schools in establishing mechanisms for identifying and treating students with psychiatric disorders (Doll, 1996); as direct service providers to children with emotional disorders such as depression (Stark, Brookman, & Frazier, 1990) and to families of preschoolers who are at-risk or have disabilities (Mowder, Widerstrom, & Sandall, 1989); as trainers of teacher consultants, in order to extend the scope of consultation services in schools (Norris, Burke, & Speer, 1990); as health-care service providers (Carlson, Paavola, & Talley, 1995; Tharinger, 1995); as systems-level interventionists (Gutkin, Henning-Stout, & Piersel; 1988; Rosenfield, 1992); and as organizational facilitators in school reform and interagency collaboration (Adelman, 1996; Curtis & Stollar, 1996; Knoff, 1996) . These suggestions are consistent with the most recent call for "school psychological reform" (Knoff, Curtis, & Batsche, 1997) in order to prepare psychologists to meet the challenges presented by social reforms (Talley & Short, 1996).

Recent surveys suggest that some change in school psychology practice is occurring, although these changes are far from being the standard in the professional school psychology. In a survey of 273 doctoral-level school psychologists who were members of the American Psychological Association, Short and Rosenthal (1995) found that most practitioners provided an array of services, including assessment (63% of the respondents), counseling (64%), and consultation (59%). However, a 1991-92 survey of 1,089 practitioners in the U.S. who were members of NASP revealed that school psychologists still devote over half of their time to psychoeducational assessment activities, with considerably less time devoted to direct intervention (20%), problem-solving consultation (16%), and systems-organizational consultation and research-evaluation (5% or less) (Reschly & Wilson, 1995). Furthermore, practitioners indicated preference for reallocation of their time, with an decrease in psychoeducational assessment (to 32%) and concomitant increases in the other activities—direct intervention, 28%; problem-solving consultation, 23%; organizational-systems consultation, 10%; and research and evaluation, 7% (Reschly & Wilson). One study provides evidence of variability based on geographical location; that is, Roberts and Rust (1994) compared time allocation for school psychologists in Iowa and Tennessee. They found that Iowa school psychologists spent comparatively more time on intervention (27%), consultation (29%), and curriculum-based assessment (7%); and less time on assessment (52%). Tennessee school psychologists, in contrast, spent more time on assessment (67%), and less on intervention (18%), consultation (18%), and curriculum-based assessment (less than 1%). The differences were attributed to a statewide reform system in Iowa oriented toward use of a problem-solving approach and provision of direct and indirect service delivery. Even with these reform efforts, it is noteworthy that psychologists still spent over 50% of their time on assessment.

Despite the repeated call and need for school psychologists' involvement in mental health service delivery, there is scant evidence for such involvement in the professional literature. Yet, conference proceedings (e.g., from the annual conventions of NASP) and informal professional contacts suggest that school psychologists are participating indirectly and directly in providing mental health services. Given the higher priority schools give to service delivery versus research and publication, it is not surprising that school psychologists are not disseminating information about programming in the professional literature. It is for this reason that the NASP Children's Services Committee focused on the identification and documentation of mental health programming by school psychologists.

Efficacy of Mental Health Programming

In this section, we summarize existing research on mental health programming, with particular focus on school-based programs and/or those that address the needs of the school-age population. We examined programming across the continuum of service provision from prevention to treatment, specifically in the areas of personal-social competence enhancement, substance abuse prevention, suicide prevention, violence prevention, sexual abuse prevention, crisis intervention, counseling, and treatment of children with emotional/behavioral disorders. We briefly describe critical features of effective programming within each of these areas.

Personal-social competence enhancement

Effective programming to enhance personal-social competency targets both cognitive and behavioral skill components, including perspective taking, interpersonal problem solving, conflict resolution, communication, assertiveness, self-control, and collaboration (Camp & Bash, 1985; Durlak, 1983; Gesten & Weissberg, 1986; Goldstein, 1988; Oden, 1986; Nastasi & DeZolt, 1994; Pellegrini & Urbain, 1985; Rotheram-Borus, 1988; Shure & Spivack, 1988; Spivack & Shure, 1974; Weissberg, Caplan, & Harwood, 1991; Weissberg & Gesten, 1982). The efficacy of cognitive-behavioral interventions for enhancing the behavioral adjustment of children and adolescents is well documented. These programs typically draw on social learning theory. Critical program features include demonstration, modeling, role-playing, performance feedback, self-monitoring, "homework" activities to promote transfer to real-life settings, and "booster" (follow-up) sessions to promote maintenance. Programs are generally less effective in promoting generalization (across time and context) than in producing immediate, context-specific results. This limitation suggests the need to create environments that support the development and enactment of target competencies through ecologically-based interventions. Examples of ecologically-based programming include implementation in naturalistic contexts such as classrooms and other peer contexts; training of socializing agents across a number of contexts (e.g., teachers, parents, peer educators); organizational or systems-level change targeted at instructional strategies (e.g., cooperative learning), discipline procedures, or general school management (e.g., shared decision making); and collaborative efforts among schools, families, and communities.

Substance abuse prevention

Programs targeted at preventing abuse of alcohol and other drugs (e.g., tobacco, marijuana) have focused on knowlege acquisition, attitude change, affective education (e.g., self-esteem enhancement), providing alternative recreational or educational activities, personal-social competence skills development (e.g., resistance skills, decision making), and behavioral change (e.g., decrease substance use). Meta-analytic studies (Bangert-Drowns, 1988; Tobler, 1986) and an extensive review of efficacy research (Nastasi & DeZolt, 1994) provide little support for programs that target knowledge acquisition or affective education without a skill-based or behavioral focus. "*The most effective programs are those designed to enhance personal-social compentencies that serve as protective factors against drug abuse (e.g., resistance or interpersonal skills), followed by programs that provide alternative activities in addition to a skill-based focus*." (Nastasi & DeZolt, 1994, p. 48). In addition, "*the features most strongly associated with behavioral change (e.g., reduction in drug use) were voluntary participation and use of peer facilitators* ." (Nastasi & DeZolt, 1994, p. 50). Furthermore, maintenance of program outcomes are facilitated by the use of peer educators, consistent involvement of program developers in implementation (e.g., through co-facilitation, consultation, monitoring) and booster (review) sessions (e.g., Botvin, Baker, Filazzola, & Botvin, 1990; Pentz, 1985).

Suicide prevention

Efforts initiated in the 1970's and 1980's to address concerns about adolescent suicide resulted in recommendations and development of school-based (and curriculum-based) suicide prevention programs (Tierney, Ramsay, & Tanney, 1990). Such programs have focused on educating students, school personnel, and parents about suicide, its risk factors, and preventive intervention strategies for those at serious risk (e.g., Ciffone, 1993; Herbert, 1989; Kalafat & Elias, 1994; Martin, Martin, & Barrett, 1987; Nelson, 1987; Shaffer, Garland, Vieland, Underwood, & Busner, 1991; Spirito, Overholster, Ashworth, Morgan, & Benedict-Drew, 1988). These programs have demonstrated efficacy regarding (a) increased knowledge about suicide and its risk factors; (b) identifying suicidal feelings in self and others; (c) fostering understanding of suicidal individuals; (d) increasing referrals, of those at risk for suicide, to mental health professionals; (e) decreasing suicide attempts; and (f) preparing students as peer counselors.

Violence prevention

The potential role of schools in violence prevention has received much attention in recent years, as exemplified by the Safe Schools Act of 1994, and related efforts to promote violence-free school environments and teach nonviolent conflict resolution (Stephens, 1994; Zins, Travis, Brown, & Knighton, 1994). As a result of such efforts, more than half of the school districts in this country have implemented educational violence-prevention programs (Glazer, 1992). The Health, Education, and Human Services Divison (1995) has documented over 750 different violence-prevention programs. Among these, the most frequently implemented are alternative schools/programs for disruptive students (66%) and conflict resolution and peer mediation programs (61%). Although efficacy is not well documented, early findings are promising (Johnson, Johnson, Dudley, & Acikgoz, 1991; Johnson, Johnson, & Dudley, 1991; Johnson, Johnson, Dudley, & Burnett, 1991; Shrumpf, Crawford, & Usadel, 1991). Evaluations of these programs suggest that peer mediation is an effective approach for resolving student conflicts and reducing discipline problems. Additionally, prevention programs designed to enhance personal-social competence, such as Goldstein's Skillstreaming program (Goldstein, 1988; Goldstein, Glick, Reiner, Zimmerman, & Coultry, 1987; Goldstein & Huff, 1993), hold promise for addressing anger managment, aggession, and violence. Furthermore, cooperative learning as an instructional strategy provides a natural context for enhancing conflict resolution skills (e.g., Deutsch, 1993; Johnson & Johnson, 1983; Nastasi & Clements, 1991). Conflict resolution in cooperative education contexts have shown cognitive and educational benefits as well (Nastasi & Clements, 1991, 1992; Nastasi, Clements, & Battista, 1990).

The Health, Education, and Human Services Division (1995) identified seven critical characteristics of promising school-based prevention programs, also advocated by researchers: (a) a comprehensive approach (e.g., across settings, individuals, developmental levels); (b) early start and long-term commitment; (c) strong leadership and disciplinary policies; (d) staff development; (e) parental involvement; (f) interagency partnerships and community linkages; and (g) culturally-sensitive and developmentally-appropriate approaches. Using these criteria, the Health, Education, and Human Services Divison identified four "state of the art" program in violence prevention—School Management and

Resources Team, Anaheim, California; Positive Adolescents Choices Training, Dayton, Ohio; Resolving Conflict Creatively Program, New York, New York; and Alternatives to Gang Membership, Paramount, California. These programs have documented efficacy with regard to reducing violent behaviors in school and/or community.

Sexual abuse prevention

The inclusion of sexual abuse prevention programming in schools is a recent phenonemon. As a result of the awareness of the mental health problems related to childhood sexual abuse, such programming was initiated (Browne & Finkelhor, 1986). Perhaps related to the recent inception, the majority of available child sexual abuse prevention programs have not been scientifically evaluated. Available evidence, however, supports the efficacy of programs that focus on behavioral skill development, using behavioral intervention approaches (Blumbeg, Chadwick, Fogarty, Speth, & Chadwick, 1991; Pouche, Yoder, & Miltenberger, 1988; Wurtele, Kast, Miller-Perrin, & Kondrick, 1989). The critical components of effective programs include the use of modeling, role playing, and behavioral rehearsal. Prevention skills include refusal of (saying "no" to) inappropriate touching; escaping from an abusive or potentially abusive situation; and informing an adult and continuing to inform until one is believed (Harvey, Forehand, Brown, & Holmes, 1988; Kolko, Moser, Litz, & Hughes, 1987; Kolko, Witte, & Fryer, 1989; Tutty, 1992; Wurtele, Saslawsky, Miller, Mars, & Britcher, 1986; Wurtele et al., 1989). Some programs also include self-defense behaviors such as kicking or yelling (Binder & McNiel, 1987); however, there is evidence to suggest that such strategies may increase risk of injury to the victim (Finkelhor, Asdigian, & Dziuba-Leatherman, 1995; Budin & Johnson, 1989; Elliott, Browne, & Kilcoyne, 1995).

Crisis intervention

Much of the current literature on crisis intervention is descriptive in nature, primarily focused on describing the response to a specfic crisis event (e.g., school bus train accident; Klingman, 1987) or providing guidelines for developing crisis intervention plans or teams (e.g., Sorenson, 1989; Thompson, 1995; Weinberg, 1990). There have been few attempts to evaluate the efficacy of crisis intervention strategies. For example, the Prevention Program for Children Experiencing Life Crisis (Felner, Norton, Cowen, & Farber, 1981) evaluated program effectiveness using an anxiety-trait measure, although results provided only weak support for efficacy. Other programs have used measures to facilitate needs assessment once the disaster occurs (e.g., Klingman, 1989). Crisis intervention is clearly an area in need of research and evaluation.

Counseling

The efficacy of counseling interventions for both children and adults has been subject to criticism for over 40 years (e.g., Levitt, 1957). More recent reviews, using meta-analytic procedures, provide evidence of the efficacy of counseling (Casey & Berman, 1985; Prout & DeMartino, 1986). The Casey and Berman study revealed that children who received counseling/therapy scored substantially better (more than 2/3 of a standard deviation) on outcome measures than untreated children. The research by Prout and DeMartino (1986) provided evidence of moderate effects from counseling interventions. Additionally, these researchers documented the superiority of behavioral therapies over non-behavioral.

Treatment of emotional/behavioral disorders

The integrity of piecemeal service provision for children and adolescents with identified emotional and behavioral disorders has been questioned in recent years (e.g., Adelman, 1993). Mental health professionals have been challenged to provide more comprehensive, coordinated services to this high-risk population (e.g., Adelman, 1993; Mattison, Morales, & Bauer, 1992; Silver, Duchnowski, Kutash, Friedman, Eisen, Prange, Brandenbuerg, & Greenbaum, 1992). In particular, interagency collaboration and parent involvement has been encouraged, in order to provide consistent long-term intervention. Innovative school programs and initiatives have been developed to meet these objectives at three different levels: prevention (e.g. Chandler, Weissberg, Cowen, & Guare, 1984), risk reduction/early identificatoin (Catron & Weiss, 1994), and treatment programs (Jordan & Hernadez, 1990). Initial efficacy results indicate that comprehensive programs hold promise for addressing the needs of students with emotional/behavioral disorders.

Summary

The purpose of this project was to identify and document exemplary school/community-based mental health programs in which school psychologists were engaged in one or more aspects of program development. We conducted an extensive literature review of mental health programming in order to document the current empirical base regarding effective programming, identify exemplary characteristics, and examine the role of the school psychologist in providing mental health services. Exemplars of effective programming were found in the areas of: (a) personal-social competence enhancement; (b) substance abuse prevention; (c) suicide prevention; (d) violence prevention; (e) sexual abuse prevention; (f) counseling; and (g) treatment of emotional/behavioral disorders. The school psychologist was seldom mentioned in the literature of mental health programming. It is important to examine characteristics of exemplary programs and the role played by the school psycholgists in these programs given the increasing need for school-based mental health services. School- and community-based mental health programs would benefit by utilizing the school psychologist as a critical player in program development, implementation, and evaluation.

SURVEY RESULTS

The purpose of the project, funded by NASP under the Children's Services Committee, was to identify and document school- and community-based mental health programs in which school psychologists were engaged in program development, implementation, and/or evaluation. "Exemplary" programs were defined by the following: (1) integrates theory, research, and practice; (2) addresses links between ecological systems (i.e., school, family, community, peer group); (3) is framed within a continuum of services (prevention, risk-reduction, early intervention, treatment); (4) uses a collaborative-participatory model in which agency staff and program consumers participate in program development, implementation, evaluation; and (5) evaluates program acceptability, integrity, and effectiveness.

Project activities included (1) an extensive literature search on school- and community-based mental health interventions; (2) soliciting nominations of exemplary programs; (3) survey development; and (4) data collection and analysis. The literature review provided the foundation for establishing the criteria for exemplary programs, examining the role of the school psychologist, and survey development. Programs were nominated by NASP state delegates, presidents of state school psychology associations, state consultants, school psychology colleagues, and directors of NASP-accredited school psychology training programs. In addition, nominations were solicited directly from programs identified through the literature search and professional conference proceedings. The survey was designed to gather information about the program model; procedures for program design, implementation, and evaluation; the nature of the school psychologist's involvement; and program demographics.

Surveys were mailed to 195 programs in 44 states. Completed surveys were received from 87 programs, representing 36 states. Of the 87 programs, 32 met all criteria for exemplary programs and included a school psychologist in program activities. Data were analyzed separately for the 87 programs and 32 exemplary programs. A summary of findings presented at the annual meeting of NASP in Anaheim, CA (April, 1997), follows.

Program Demographics

1. Approximately 90% of the mental health programs provided services in public schools, approximately 25% provided services in community mental health agencies, and approximately 40% provided services in "other" contexts such as private non-profit agencies, religious organizations, corrections/police agencies, hospitals, social service agencies, private practice, preschools/day cares, and town government.
2. More than 50% of programs were located in suburban areas, 40% in urban, and 30% rural.
3. Program recipients were overwhelmingly male (2/3), aged 7-16 in participating programs and aged 6-14 in exemplary programs.
4. Ethnic representation was consistent with national demographics for the general population.

Program Staff

1. Over 80% of all programs and over 90% of exemplary programs reported that school psychologists were involved in all three aspects of programming (i.e., design, implementation, and evaluation).
2. School administrators were involved in programming in the majority of programs.
3. A greater number of programs included special education teachers, compared to regular education teachers, in program design, implementation and evaluation. This finding may be related to the finding that 50% of the programs were funded as special education. Special education teachers in exemplary programs were more likely to be involved in all three aspects of programs than special education teachers in all programs.
4. Findings suggest that a participatory model of mental health programming was being used by the vast majority of programs.
    a. Parents were involved in all three components of programming. Specifically, parents were involved in the implementation of 75% of exemplary programs and 52% of all programs.

b. Paraprofessionals, peers, and support staff (social workers, counselors) were found to be more involved in program implementation than in design or evaluation.

c. Fourteen to 28% of all programs and 25 to 34% of exemplary programs included community members and community agencies in program design, implementation and/or evaluation.

Funding

1. The majority of programs were funded by schools (60 to 70%) and/or external grants (50-60%).
2. Half of all programs were funded with special education funds.
3. Almost 70% of exemplary programs were funded as non-special education support services.

School Psychologist's Role

1. School psychologists involved in mental health programming spent less than 30% of their total job time in assessment, 20% in counseling, approximately 25% in consultation, about 15% in prevention and less than 10% in research. These psychologists devoted 40% to 50% of their time to mental health programming.
2. Of the time devoted to the program, school psychologists spent the majority of their time—approximately 60%—in program implementation. The remaining 40% was divided equally between program design and evaluation.

Program Model

1. The vast majority, 84% of all programs and 97% of exemplary programs, had a theoretical-empirical basis for program development. The prevailing theoretical bases for program development were behavioral, social learning, cognitive/cognitive-behavioral and developmental. Ecological, psycho-educational and humanistic theories were also well represented. Over 90% of the programs reported using multiple theories. Most programs reported reliance on research regarding program efficacy, population needs, and risk and protective factors.

2. In designing programs, most respondents reported conducting literature searches and needs assessments; tailoring program to specific population needs; piloting the program; and developing plans for addressing potential barriers, accessing necessary resources, and evaluating the program.
3. Most programs (75%) provided services at more than one of the four levels: prevention (level 1), risk reduction (level 2), early intervention (level 3), treatment (level 4).
4. With regard to staff preparation, a large majority of programs (approximately 90%) provided staff training and ongoing consultation.
5. The majority of programs used the following strategies to ensure generalization of program outcomes: intervention in natural settings, reinforcement in other settings, training in self-monitoring, parent and teacher training, and follow-up/booster sessions.
6. The majority of the programs evaluated acceptability (81%), integrity (66%), and efficacy (85%); 40% of all programs conducted follow-up evaluations. The majority of programs reported using several evaluation techniques, including observations, interviews, self-report instruments, rating scales and anecdotal data. With regard to program outcomes, 40% of all programs evaluated knowledge, 49% attitudes/beliefs, and 64% evaluated target behaviors. Respective percentages for exemplary programs were 56%, 69%, and 84%. With regard to transfer and maintenance of outcomes, 30-40% of all programs evaluated generalization compared to approximately 50 to 60% of exemplary programs. A large majority of programs (approximately 80%) used school discipline problems as an outcome variable and 50% used school violence. Despite reported program evaluation efforts, less than half of the programs reported having results in written form.

Program Descriptions

Participating programs were identified on the basis of the following exemplary characteristics (as reflected in responses to survey questions):

I. School psychologist involvement—school psychologist participates in program design, implementation, and/or evaluation.

II. Ecological-collaborative model—major stakeholders are involved in program design, implementation, and/or evaluation. Major stakeholders were defined as school staff (teachers, administrators, mental health support staff), parents, peers, participants, community agency staff and community members.

III. Theoretical base—one or more psychological theories provided the basis for program development.

IV. Empirical base—research on program efficacy, population needs, risk/protective factors, or other research provided the basis for program development

V. Evaluation—the following program aspects were evaluated:

Acceptability —the degree to which program developers, implementers, evaluators, and recipients embrace program philosophy, goals and objects, and procedures.

Integrity—the degree to which the program is implemented as planned.

Efficacy—the effectiveness of the program for meeting the intended goals or outcomes.

VI. Level of service provision—mental health services were provided at one or more of the following levels:

Level 1. Prevention—directed at the general population of students and designed to foster development of individual personal-social competencies and/or creation of supportive environments (e.g., social skills or drug prevention program as part of the school's curriculum).

Level 2. Risk reduction—designed to address the needs and problems specific to at-risk populations, based on individual and/or environmental factors (e.g., children of divorce).

Level 3. Early intervention—designed to address the needs and problems of individuals experiencing mild adjustment difficulties (e.g., mild depression, anxiety or behavioral problems), for the purposes of treating existing problems and reducing the risk of more severe problems.

Level 4. Treatment—designed for individuals experiencing moderate to severe emotional and behavioral disorders (e.g., clinical depression, conduct problems), for the purpose of treating the identified problems.

The following programs provide illustrations of the exemplary criteria. The 67 illustrative programs represent 32 states. Program contacts were asked to provide program descriptions and to grant permission for the information about the program to be published. Only those programs that granted permission are included in this document.

ALABAMA (AL)

Children's Day Treatment Program
Baldwin County Public Schools

Faron Hollinger, Ed.D., NCSP
Division Superintendent/Special Services
6925 Twin Beech Road
Fairhope, AL 36532
334-990-2235 (Phone)
334-990-2232 (Fax)

PROGRAM DESCRIPTION

The Day Treatment Program is a joint initiative between the Baldwin County Board of Education and the Baldwin County Mental Health Center. The purpose of the Day Treatment Program is to provide therapy and behavioral management techniques for students with behavioral and emotional problems. This program is designed as a Least Restrictive Environment (LRE) option for special education students experiencing emotional difficulties. The objectives of the program are to (a) improve self-esteem; (b) teach the importance of cooperation; (c) improve peer relations; (d) reduce self-defeating behaviors; (e) teach self-control; (f) teach students to ask questions; (g) improve social skills; and (h) inspire creativity and appropriate self-expression. School psychologists participated in the design, implementation and evaluation of the day treatment program.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school, school-linked, community mental health agency

POPULATION

#students/clients	10
Age	7-11
Grade	Elementary school and middle school

FUNDING SOURCES

External grants (Alabama Department of Mental Health)
School funded
Linked to school-based health clinic
Funded with special education funds

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Improve academic functioning
Support school transitions
Parental involvement
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Classroom-based
Non-classroom based
Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Parent
Teacher
Multidisciplinary Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
Outside Agency

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Multiple levels of screening
Standardized tests
Interviews
Curriculum-based measures

CRITERIA FOR TERMINATION
Meet outcome criteria
Complete specified program
Deemed inappropriate for program

GENERALIZATION PROCEDURES
Training in natural context
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Parent training
Teacher training
Implementation by multiple facilitators/educators

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Self-report
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Target behaviors (individualized)
Specific problem behaviors (individualized)
Social problem solving skills
Academic functioning
Social skills
Emotional well-being
Reduction in risky behavior (self-destructive)
Self-esteem
Self-efficacy
Generalization of program effects to other settings
Maintenance of program effects
Move or transfer to less restrictive setting
Reduction in school discipline problems
Reduction in school violence
Increase in attendance rates
Increase in inclusion/retention in regular education
Lower rate of hospitalization

WRITTEN MATERIALS AVAILABLE

Description of program design
Program guide for implementation
Intervention techniques
Staff training
Intake and exit procedures
Goals and objectives
Definition of population served
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program implementation	5%
Program evaluation	95%

ECOLOGICAL-COLLABORATIVE MODEL
(Program Participants)
School Psychologist
Psychiatrist
Certified Counselor
Special Education Teachers
School Administrator
Paraprofessionals
Parents
Program Recipients

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on program efficacy
Research on population needs

PROGRAM EVALUATION
Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level IV.	Treatment

33

CALIFORNIA (CA)

Early Assistance for Students and Families
Los Angeles Unified School District (LAUSD)

Linda Taylor
Clinical Psychologist
School Mental Health
Valley Center
6651 Balboa Blvd.
Van Nuys, CA 91406
818-997-2640 (Phone)
818-996-9850 (Fax)

PROGRAM DESCRIPTION

The mission of Early Assistance for Students and Families is to address the needs of dropouts, specifically to: (a) enhance school-based intervention strategies for addressing barriers to learning and performing; and (b) develop a diffusion model for introducing, spreading, institutionalizing, and evolving new approaches in schools. Strategically, demonstration sites are selected that feed into secondary schools with high dropout rates. Such schools have relatively large enrollments, serve students from ethnic families who are poor, transient, and are limited in English proficiency. The Los Angeles Unified School District (LAUSD) has undertaken this work in collaboration with UCLA. A number of school psychologists are working as Organization Facilitators; that is, change agents responsible for introducing and implementing new programs in high school. Program evaluation is currently being conducted and focuses on the process of system change.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school

POPULATION

# students/clients	640
Age	5-18
Grade	Kindergarten through high school

Racial/ethnic composition

African American	14%
Asian	4%
Caucasian	11%
Hispanic	68%
Other	3%

FUNDING SOURCES

External grants
School funded
Funded as non-special education support services

PROGRAM GOALS

Reduce referrals to special education
Prevent placement in more restrictive setting
Prevent exacerbation of mild adjustment difficulties
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
School-wide
District-wide
Community-based

COMPONENTS
Staff training
Ongoing consultation with program staff

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
School and community needs assessment

CRITERIA FOR TERMINATION
Meet outcome criteria
Complete specified program
Deemed inappropriate for program

GENERALIZATION PROCEDURES
Training in natural context
Training in multiple settings
Implementation by multiple facilitators/educators
Ongoing supervision of staff

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Self-report
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Target behaviors (formation of teams)
Generalization of program effects to other settings
Maintenance of program effects
Reduction in school discipline problems
Reduction in school violence
Increase in attendance rates
Increase in graduation rates
Increase in inclusion/retention in regular education
Reduction in referrals to special education
Reduction in special education placements

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Program guide for implementation
Goals and objectives
Theoretical-empirical foundation
Description of program model

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	5%
Program implementation	75%
Program evaluation	20%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Certified Counselor
School Nurse
School Administrator
School Board Member
Parents
Community Members

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

COLORADO (CO)

At-Risk Prevention Program
Dry Creek Elementary School

Cathy Lines, Ph.D., NCSP
School Psychologist
7686 East Hinsdale Avenue
Englewood, CO 80112
303-770-2144 (Phone)
303-743-3670 ext. 5140 (Phone)
303-770-1693 (Fax)

PROGRAM DESCRIPTION

The Dry Creek Elementary School At-Risk Prevention Program is a multi-faceted model based upon the resiliency and developmental assets research from Burns, Benson, and colleagues (1994). Components include: (a) student/staff mentor program (PAL); (b) parent education seminars; (c) ongoing monitoring of students; (d) school-wide bully-proofing and social skills training; (e) extracurricular activities; (f) Caring Kids Recognition Program; (g) student opinion surveys; (h) individual and group counseling services; and (i) staff training. Encouraging all staff to recognize students' strengths has been a focus. PAL is a formal program of mentorship, coordinated through an identified team (the Care Team) that screens students for services on an informal basis. Students are nominated for PAL by a staff member or parent. Goals of PAL are:

1. To foster in students a sense of belonging or bonding to the school community.
2. To develop a strong support system at school for at-risk students.
3. To promote an involvement in the school and community.
4. To identify students who would benefit most by having an adult be a "special friend."

A school psychologist was involved in the development, implementation and evaluation of the At-Risk Prevention program. Specifically, the school psychologist participated in facilitation, leadership, staff training, consultation, and communication with administration.

PAL was developed in 1992 and through ongoing evaluation/training has continued to be well supported and successful. The program has been evaluated by staff, students, and parents. Evaluation data include classroom ratings (teacher report), attendance rates, academic achievement, parent evaluation, and participant information. Parent evaluations provide positive support for the program. Teachers reported that of students participating in PAL 67% improved in academic performance, 50% in classroom behavior, 44% in class participation, 50% in social skills, and 78% in school attendance. In addition, parent involvement increased by 39%.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
# students/clients	350
Age	5-12
Grade	Elementary school
Gender	50% female, 50% male
Racial/ethnic composition	
African American	1%
Asian	3%
Caucasian	93%
Hispanic	2%
Indian	<1%

FUNDING SOURCES

School funded (minimal funding needed)

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Violence prevention
Dropout prevention
Improve academic functioning

Support school transitions
Parental involvement
Risk reduction

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Large group
Classroom-based
Non-classroom based
School-wide
Community-based (parent education seminars)

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent

REFERRAL SOURCES
Self
Parent
Teacher
Multidisplinary Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
School Discipline Officer

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Interviews

CRITERIA FOR TERMINATION
(not applicable)

GENERALIZATION PROCEDURES
Training in natural context
Teaching self-monitoring or verbal mediators
Parent training
Teacher training
Implementation by multiple facilitators/educators
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Interview
Self-report
Rating scales
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Attitudes/beliefs
Reduction in risky behavior (as judged by staff)

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Evaluation procedures
Staff training
Intake and exit procedures
Theoretical-empirical foundation
Description of program model

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program design/planning	45%
Program implementation	45%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Certified Social Worker
Regular Education Teachers
Special Education Teachers
School Nurse
School Administrator
Paraprofessionals (Teaching Assistants)
Parents
Program Recipients
Peers

THEORETICAL BASE
Humanistic/Resiliency

EMPIRICAL BASE
Research on program efficacy
Research on risk and protective factors

PROGRAM EVALUATION
Program acceptability
Program integrity
Program efficacy (outcome, staff evaluation)

LEVELS OF SERVICE PROVISION

Level I.	Prevention

Douglas County Behavior Team
Douglas County School District

John Stanek & John Doherty
Project Coordinators
Douglas County School District
620 Wilcox Street
Castle Rock, CO 80104-1739
303-688-3195 (Phone)

PROGRAM DESCRIPTION

The Douglas County Behavior Team is a district-wide consultation team that works with teachers regarding student behavior problems. The emphasis is on helping teachers keep students with problems in the mainstream. This treatment program serves students, ages 5 to 18 years, with moderate to severe mental health problems. School psychologists are involved with the program design, implementation and evaluation. Two school psychologists are also members of a five-core team who work in collaboration with teachers of students with learning disabilities, multiple disabilities, and non-categorical disabilities. Within the first 3 years of the program, the behavior support team made 230 school visits and handled 95 student referrals. Evaluation of the behavior team by referral agents indicated high ratings on collaboration, expertise, and information provided. In response to lower rates regarding response time and follow-up, an additional staff member has been added to the team.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
# students/clients	53
Age	5-18
Grade	Preschool through high school
Gender	20% female, 80% male
Racial/ethnic composition	
African American	1%
Caucasian	97%
Hispanic	2%

FUNDING SOURCES

School funded
Funded with special education funds

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Generalization of program effects

PROGRAM IMPLEMENTATION

FORMAT
District-wide

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)
Consultation and collaboration with building level teams

REFERRAL SOURCES
Multidisciplinary Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Discipline Officer
Special Education Director

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Standardized tests
Interviews

Curriculum-based measures
Outcome analysis

CRITERIA FOR TERMINATION
Other (building level team status)

GENERALIZATION PROCEDURES
Reinforcement in other settings
Training in multiple settings
Teacher training
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Self-report
Rating scales

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Target behaviors (replacement behaviors to be taught and reinforced)
Specific problem behaviors (behaviors that interfere with academic achievement)
Social problem solving skills
Social skills
Emotional well-being
Reduction in risky behavior (behaviors that interfere with instruction and learning)
Self-esteem
Generalization of program effects to other settings
Maintenance of program effects
Move or transfer to less restrictive setting
Reduction in school discipline problems
Reduction in school violence
Increase in attendance rates
Increase in inclusion/retention in regular education

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Program guide for implementation
Intervention techniques
Evaluation procedures
Evaluation results
Staff training
Intake and exit procedures
Goals and objectives
Theoretical-empirical foundation
Description of program model
Definition of population served
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program design/planning	15%
Program implementation	75%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Certified Social Worker
Special Education Teachers
School Administrator
Paraprofessionals
Parents
Peers
Community Members

THEORETICAL BASE
Multiple

PROGRAM EVALUATION
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION
Level IV. Treatment

Respect, Unity, and Dignity for Everyone (R.U.D.E) Ponderosa High School

Ruth Gonzalez, Ph.D., NCSP
7007 East Bayou Rd.
Parkes, CO 80134
303-721-8122 (Phone)
303-841-5623 (Fax)

PROGRAM DESCRIPTION

Respect, Unity, and Dignity for Everyone (R.U.D.E.) was initiated several years ago by students and staff concerned about disrespectful attitudes towards others. R.U.D.E. is a student-run organization which encourages respectful behaviors and attitudes among all people. R.U.D.E. organizes two major projects each year which have included recognition of individual students, assistance to other people, in-class discussion of practical methods for showing respect, and on-going communication between people. R.U.D.E. is the umbrella organization for all activities at school that promote positive behavior and attitudes. The sub-organizations include a diversity club, peer counselors, support groups, issues-driven theater productions, and student government.

The school psychologist designed the program and implements the program in collaboration with students, faculty, and administration. She also reviews the progress of the program and goals annually. An informal evaluation of the program has been conducted but data is not yet available.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
# students/clients	22,000
Age	15-21
Grade	High school and other grades (18-21)
Gender	45% female, 55% male
Racial/ethnic composition	
African American	2%
Asian	8%
Caucasian	80%
Hispanic	10%

FUNDING SOURCES

The school psychologist "scrounges" for funds

PROGRAM GOALS

Enhance social competence
Increase social problem solving skills
Foster appropriate expression of emotions
Encourage unity and respect for each other
Develop a sense of community with peer role models

PROGRAM IMPLEMENTATION

FORMAT
Large group
Non-classroom based
School-wide

COMPONENTS
Ongoing consultation with program staff
Obtain written consent

REFERRAL SOURCES
Self
Parent
Teacher
Counselor

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Self-selection by students

GENERALIZATION PROCEDURES
Reinforcement in other settings
Booster or follow-up sessions
School-wide public relations releases

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Attitudes/beliefs
Target behaviors (conflict resolution)
Social problem solving skills
Reduction in risky behavior
Self-esteem
Reduction in school discipline problems
Community outcomes
Self-empowerment

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	33%
Program implementation	66%
Program evaluation	34%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Regular Education Teachers
Special Education Teachers
Parents
Program Recipients

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on population needs

PROGRAM EVALUATION
Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level II.	Early intervention
Level IV.	Treatment

School-Community Facilitator Model Service
Greeley School District

Michael Hoover, Ed.D.
Program Coordinator
811 15th Street
Greeley, CO 80631
970-352-1543 (Phone)
970-353-2624 (Fax)
mikeh@alpha.psd.k12.co.us

PROGRAM DESCRIPTION

The school-community facilitator model is a comprehensive model incorporating the roles of the traditional school psychologist, school counselor, and school social worker. A full-time school psychologist is assigned to every school site and provides assessment, counseling, consultation, and liaison services between families and community agencies. The model has resulted in changes in the school psychologist's role from primarily assessment to a comprehensive clinical role. The level of primary intervention has increased and the number of referrals and assessments in the area of Significant Identifiable Emotional Disturbance has decreased.

A feature of the school-community facilitator model is the Carson Day Treatment Program, a comprehensive program which provides academic and affective support to students ages five to twelve and their families. The goal of the program is to prevent placement in a 24 hour program and facilitate the return of students to their home schools. Carson Day Treatment Program is a collaborative project with services from the school district, local mental health agency, and University of Northern Colorado Special Education Department. The District meets the academic needs of the child by working with on-site therapists who provide individual and family therapy and parenting groups. The university staff focuses on evaluation of the program and the transition of students back to their home schools. The program has proven to be effective in that approximately 70% of the participants are successfully transitioned back to their home schools. The prevailing issue with those who are not successfully transitioned is lack of parental involvement and follow-up.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school, community health agency, university

POPULATION

# students/clients	12
Age	5-12
Grade	Elementary school
Gender	100% male

Racial/ethnic composition

Caucasian	75%
Hispanic	20%
Native American	5%

FUNDING SOURCES

School funded
Funded with special education funds
Funded as non-special education support services
Funding from private agencies
Medicaid
Department of Social Services

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Violence prevention
Risk reduction
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Small group
Classroom-based
Community-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Parent
Teacher
Multidisciplinary Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
Outside Agency
Other districts

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Multiple levels of screening
Standardized tests
Interviews
Screening Committee

CRITERIA FOR TERMINATION
Meet outcome criteria
Deemed inappropriate for program

ATTRITION RATE: 20%

GENERALIZATION PROCEDURES
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Parent training
Teacher training
Implementation by multiple facilitators/educators

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Rating scales
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Target behaviors (Individualized Educational Plans)
Specific problem behaviors (Individualized Educational Plans)
Social problem solving skills
Academic functioning
Generalization of program effects to other settings
Move or transfer to less restrictive setting
Increase in inclusion/retention in regular education
Lower rate of hospitalization

WRITTEN MATERIALS AVAILABLE

Program guide for implementation
Cost-benefit analysis
Intake and exit procedures
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	5%
Program implementation	5%
Program evaluation	90%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Counselor
Special Education Teachers

School Nurse
School Administrator
Community Mental Health Agency
Paraprofessionals
Parents

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on program efficacy

PROGRAM EVALUATION
Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level IV.	Treatment

CONNECTICUT (CT)

Stop, Look, and Listen
Westport School District

Barbara Fischetti
Coordinator of Psychological Services
Westport School District
72 North Avenue
Westport, CT 06880
860-454-8990 (Phone)
860-226-8370 (Fax)

PROGRAM DESCRIPTION

The mission of Stop, Look, and Listen is to modify the behaviors of students who exhibit Attention Deficit Hyperactivity Disorder-like behaviors, and promote generalization of the newly acquired behaviors. The program utilizes a cognitive-behavioral approach. The school psychologist in each building conducts a group for students exhibiting ADHD-like behaviors and provides consultation to foster generalization to the classroom context.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school

POPULATION

# students/clients	1792
Age	8-10
Grade	Elementary school
Gender	48% female, 52% male

Racial/ethnic composition

African American	1%
Asian	1%
Caucasian	95%
Hispanic	2%
Native American	1%

FUNDING SOURCES

School funded
Funded as non-special education support services

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Improve academic functioning
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Small group
Large group
Classroom-based
Non-classroom based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Self
Parent
Teacher
Prereferral Intervention Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Staff referral, parent referral

CRITERIA FOR TERMINATION
Complete specified program

GENERALIZATION PROCEDURES
Training in natural context
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Training in multiple settings
Teacher training

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Self-report

OUTCOMES THAT ARE EVALUATED

Knowledge
Attitudes/beliefs
Target behaviors (ADHD-like behaviors, i.e., impulsivity)
Specific problem behaviors (ADHD behaviors)
Social skills
Generalization of program effects to other settings
Maintenance of program effects
Reduction in school discipline problems
Reduction in referrals to special education

WRITTEN MATERIALS AVAILABLE

Curriculum
Staff training
Procedures for insuring generalization of program effects
Definition of population served
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	10%
Program implementation	80%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Regular Education Teachers
Special Education Teachers
School Administrator
Parents
Program Recipients

THEORETICAL BASE

Cognitive/cognitive-behavioral

EMPIRICAL BASE

Research on population needs

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level II.	Risk reduction
Level III.	Early intervention

Quit Smoking Clinic
Staples High School
Westport School District

Barbara Fischetti
Coordinator of Psychological Services
Staples High School
70 North Avenue
Westport, CT 06880
860-222-1209 ext. 747 (Phone)
860-222-1719 (Fax)

PROGRAM DESCRIPTION

The purpose of the program is to provide students with information on smoking and successful techniques for quitting. The school psychologist has been involved in the design, implementation, and evaluation of the program.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school

POPULATION

# students/clients	938
Age	13-18
Grade	High school
Gender	52% female, 48% male
Racial/ethnic composition	
African American	1%
Asian	3%
Caucasian	94%
Hispanic	2%

FUNDING SOURCES

School funded
Funded as non-special education support services

PROGRAM GOALS

Increase participation in regular education
Reduce specific behavioral problems
Increase self-efficacyRisk reduction

PROGRAM IMPLEMENTATION

FORMAT
Small group
Non-classroom based

COMPONENTS
Staff training

REFERRAL SOURCES
Self
Parent
Teacher
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
School Discipline Officer

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Discipline code

CRITERIA FOR TERMINATION
Complete specified program

GENERALIZATION PROCEDURES
Referral to Cessation Clinics

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Self-report

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Target behaviors (smoking)
Reduction in risky behavior (quit smoking)
Reduction in school discipline problems

WRITTEN MATERIALS AVAILABLE

Description of program design
Program guide for implementation
Curriculum
Evaluation procedures
Intake and exit procedures
Definition of population served
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program design/planning	5%
Program implementation	90%
Program evaluation	5%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
School Nurse
Program Recipients

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on program efficacy

PROGRAM EVALUATION
Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level II.	Risk reduction
Level III.	Early intervention

FLORIDA (FL)

Modified Student Support Services Team
Haines City High School

Catherine Boek
School Psychologist
2800 Hornet Drive
Haines City, FL 33844
941-421-3298 (Phone)
941-421-3283 (Fax)

PROGRAM DESCRIPTION

The Haines City Modified Student Support Services Team was created to ensure the delivery of comprehensive health services to students. The project staff includes two nurses, two social workers, one psychologist, and a part-time health clinic aide. The team provides prevention and intervention services to students in 3 schools and the district's two Teenage Parent Programs. Program goals and objectives include improving student health and self-esteem; preventing teenage pregnancy; decreasing drug/alcohol abuse and other risk behaviors; and improving services to students including health education, counseling, and extracurricular activities.

The school psychologist (a) conducts individual and group counseling; (b) teaches classes on drug abuse prevention, teenage pregnancy prevention, and wellness; (c) coordinates PRIDE clubs, peer mediation, and peer tutoring; (d) assists teachers with classroom management techniques; and (e) with other school psychologists, conducts multi-media assembly productions promoting abstinence, literacy, and other healthy choices.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
# student/clients	2646
Age	5-21
Grade	Preschool through high school
Gender	51% female, 49% male

Racial/ethnic composition

African American	38%
Asian	1%
Caucasian	45%
Hispanic	15%

FUNDING SOURCES

External grants

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Parental involvement
Risk reduction

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Large group
Classroom-based
Non-classroom based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent

REFERRAL SOURCES
Self
Parent
Teacher
Prereferral Intervention Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
School Discipline Officer

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Interviews

GENERALIZATION PROCEDURES
Training in natural context
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Parent training
Teacher training
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Anecdotal records
Archival records

OUTCOMES THAT ARE EVALUATED
Target behaviors (improve student health)
Specific problem behaviors (teen pregnancy, conflict resolution)
Social problem solving skills
Social skills
Reduction in risky behavior (drug use)
Reduction in school discipline problems
Reduction in school violence

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)
Program implementation 100%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
School Nurse
Community Mental Health Agency
Peers

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION
Program acceptability
Program integrity

LEVELS OF SERVICE PROVISION

Level I	Prevention
Level II	Risk reduction

GEORGIA (GA)

CSRA Transitional Center
Richmond County Board of Education

Charles Bartholomew, Ph.D.
School Psychologist
Psychological Services
3110 Lake Forest Drive
Augusta, GA 30909
706-731-8700 (Phone)
706-731-8709 (Fax)

PROGRAM DESCRIPTION

The CSRA Transitional Center, Inc. is a comprehensive community-based prevention and intervention program for children who are at risk for school adjustment, learning problems, delinquency, and violence (as victims or perpetrators). The program includes five key components identified by the United States Office of Juvenile Justice as effective in helping at-risk youth avoid delinquent activity. The goal is to help young children make better behavioral choices, particularly when faced with a situation where delinquent acts are the common response. Specific objectives include: (a) developing self-control and a wider repertoire of behavioral responses; (b) enhancing verbal communication skills; (c) enhancing social competence and school readiness; and (d)ultimately reducing the epidemic of delinquency and violence in the community. A school psychologist has had and continues to have the leading role in program design, implementation and evaluation. Program evaluation revealed that the CSRA Transitional Center is effective in reducing delinquent behavior in high risk populations and improving verbal communication and problem solving skills.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school, community-based prevention initiative

POPULATION	
# students/clients	30
Age	8-16
Grade	Elementary school, middle school
Gender	100% male
Racial/ethnic composition	
African American	90%
Caucasian	10%

FUNDING SOURCES

External grants (state and city/county government)
Medicaid
Private insurance

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Increase participation in regular education
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Risk reduction
Generalization of program effects
Individualized program goals

PROGRAM IMPLEMENTATION

FORMAT
Large group
Non-classroom based
Community-based

COMPONENTS
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Multidisciplinary Team
Prereferral Intervention Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
Juvenile Court

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Multiple levels of screening
Interviews

CRITERIA FOR TERMINATION
Meet outcome criteria
Complete specified program

GENERALIZATION PROCEDURES
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Training in multiple settings
Implementation by multiple facilitators/educators

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Anecdotal records
Parent, teacher, and court reports

OUTCOMES THAT ARE EVALUATED
Target behaviors
Social problem solving skills
Reduction in risky behavior
Generalization of program effects to other settings
Maintenance of program effects
Reduction in school discipline problems
Reduction in school violence
Community outcomes (reduction in illegal offenses and violence)

WRITTEN MATERIALS AVAILABLE

Intervention techniques
Intake and exit procedures
Goals and objectives
Definition of population served
Eligibility criteria

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)
Program design/planning 30%
Program implementation 40%
Program evaluation 30%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Administrator
School Board Member
Community Mental Health Agency
Paraprofessionals
Parents
Program Recipients
Community Members

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on program efficacy
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION
Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level II.	Risk reduction
Level III.	Early intervention

IDAHO (ID)

Grieving Support Group
Boise High School

Ken Dunbar, Ed.D., NCSP
School Psychologist
Boise High School
1010 Washington Street
Boise, ID 83702
208-338-3575 (Phone)
208-338-3654 (Fax)

PROGRAM DESCRIPTION

The Grieving Support Group serves students who have experienced the death of a family member or close friend. The school social worker and school psychologist co-lead the group which meets weekly during the school day for ten weeks. Group members are provided a safe environment to express their individual grief with peers and the professional leaders. Communication is established with the students' parents and teachers. Session content includes both emotional processing activities and instruction about the grieving process. The program was designed, implemented, and evaluated by the school psychologist. Program outcomes are evaluated through student responses to rating scale items and open-ended questions.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
# students/clients	18 per year
Age	15-18
Grade	High school
Gender	50% female, 50% male
Racial/ethnic composition	
African American	5%
Caucasian	76%
Hispanic	9%

FUNDING SOURCES

School funded
Funded as non-special education support services

PROGRAM GOALS

Increase self-esteem
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Increase self-efficacy
Foster appropriate expression of emotions
Risk reduction
Generalization of program effects

PROGRAM IMPLEMENTATION

FORMAT
Small group
Non-classroom based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent

REFERRAL SOURCES
Self
Parent
Teacher
Multidisciplinary Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
School Discipline Officer

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Interviews

CRITERIA FOR TERMINATION
Complete specified program

GENERALIZATION PROCEDURES
Individual follow-up

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Interview
Self-report
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Emotional well-being
Reduction in risky behavior (attendance, social problems)
Reduction in school discipline problems
Increase in attendance rates

WRITTEN MATERIALS AVAILABLE

Description of program design
Program guide for implementation
Curriculum
Intervention techniques
Evaluation procedures
Intake and exit procedures
Goals and objectives
Description of program model
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	5%
Program implementation	90%
Program evaluation	5%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Program Recipients

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level II. Risk reduction

ILLINOIS (IL)

Emotional and Behavioral Disabilities (EBD) Network
LaGrange Area Department of Special Education (LADSE)

Michael T. McElherne
Program Coordinator
1301 W. Cossitt Avenue
LaGrange, IL 60525
708-354-5730 (Phone)
708-352-5994 (Fax)

PROGRAM DESCRIPTION

The LaGrange Area Department of Special Education (LADSE) first implemented the Emotional and Behavioral Disabilities (EBD) Network in the Fall of 1994. LADSE is a special education cooperative providing services to 16 school districts. The three-tiered EBD Network strengthens traditional, existing school resources by using wraparound planning for students and families. The plan identifies the need for additional supports which are located in or created in the community. Students in the EBD Network are supported by staff in non-traditional roles. Family service facilitators support the family with regard to difficulties they have identified. Team teachers and technical assistance facilitators provide hands-on support to classroom teachers and support the on-going professional development of anyone in the Network who requests information, problem-solving, or case consultation. Trained respite workers supplement network and family resources and help coordinate plans. The LADSE EBD Network offers a continuum of service options for students with EBD, including: Level I self-contained classrooms, Level II inclusion-based support and Level III prevention activities.

School psychologists are core members of the Student Support Teams, who refer students to the EBD Network, and the Child and Family Wraparound Planning Team. School psychologists attend training and inservice activities, then return to Student Support Teams to apply the interventions and strategies. Strength-based planning becomes the focus of their assessment and recommendations for programming.

Beginning in 1993-1994, standardization data were collected as part of a statewide evaluation of school-based systems change projects conducted through LADSE. The data are focused on the 157 students and their families who received services from 1993-1995. 21 of the 47 LADSE EBD Network students were included in the preliminary analysis of the statewide evaluation. This analysis showed that students who were referred for services through the wraparound approach: (a) experienced a significant stabilization of their living environments; (b) had fewer out-of-home placements; (c) spent more days living in the home of their parents; (d) had a significant reduction in the use of psychiatric hospitalizations; and (e) showed improvement in emotional and behavioral functioning, specifically with regard to social problems, thought problems, attention problems, and aggressive behavior. As of 1995, 57 students are in the LADSE data base. A March review of EBD Network students indicated that 85% of these students are involved with community mental health providers and 95% of the school-based wraparound plans include support for families. A preliminary analysis of placements indicated a reduced number of hospitalization and zero days of homebound instruction.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school

POPULATION

# students/clients	59
Age	5 to 15
Grade	Preschool through high school
Gender	10% female, 90% male
Racial/ethnic composition	
African American	4%
Caucasian	93%
Hispanic	3%

FUNDING SOURCES

External grants (Illinois State Board of Education)
School funded
School mandated

Funded with special education funds
Funded as non-special education support services (approximately one-third of funding)

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Reduce referrals to special education
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Crisis intervention
Improve academic functioning
Support school transitions
Parental involvement
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT

Individual
Small group
Classroom-based
School-wide
Community-based (community resources accessed in wrap plans)
Home-based

COMPONENTS

Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)
Flexibility in service delivery

REFERRAL SOURCES

Parent
Teacher
Multidisplinary Team
Prereferral Intervention Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
Outside Agency
Illinois Federation of Families

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY

Direct observation
Behavioral checklists
Multiple levels of screening
Standardized tests
Interviews
Curriculum-based measures

CRITERIA FOR TERMINATION

Meet outcome criteria
Most students have life-long conditions that require continuous direct or indirect support

ATTRITION RATE: 78% of the students maintained their placement or moved to a less restrictive setting.

GENERALIZATION PROCEDURES

Training in natural context
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Training in multiple settings
Parent training
Teacher training
Implementation by multiple facilitators/educators
Booster or follow-up sessions
Focus groups to identify individual needs of teachers and schools

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES

Observation
Interview
Self-report
Rating scales
Standardized tests
Anecdotal records

OUTCOMES THAT ARE EVALUATED

Knowledge
Attitudes/beliefs
Target behaviors (for student, family, school staff)
Specific problem behaviors (that would interrupt home, school, community environment)
Social problem solving skills
Academic functioning
Social skills
Emotional well-being
Reduction in risky behavior (legal involvement, self-harm)
Self-esteem
Self-efficacy
Generalization of program effects to other settings

Maintenance of program effects
Move or transfer to less restrictive setting
Reduction in school discipline problems
Reduction in school violence
Increase in attendance rates
Increase in graduation rates
Increase in inclusion/retention in regular education
Reduction in referrals to special education
Reduction in special education placements
Lower rate of hospitalization
Community outcomes

WRITTEN MATERIALS AVAILABLE

Description of program design (brochure "EBD Network")
Curriculum (use curriculum of home school with modifications, if necessary)
Intervention techniques
Evaluation procedures
Evaluation results
Staff training
Intake and exit procedures
Procedures for insuring generalization of program effects
Goals and objectives
Description of program model
Definition of population served
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	10%
Program implementation	80%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Nurse
School Administrator
Community Mental Health Agency
Paraprofessionals
Parents
Program Recipients
Peers
Community Members
Community Agency Respite Workers
Other School Staff (Maintenance Workers, Bus Drivers, Lunchroom Aides)
Employers
Park & Recreation Leaders

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

Northern Suburban Special Education District (NSSED)
Illinois State Board of Education

Barbara Kaplan, MA
Special Education Consultant
760 Red Oak Lane
Highland Park, IL 60035
847-831-5100 (Phone)
847-831-5108 (Fax)

PROGRAM DESCRIPTION

In 1991, the Northern Suburban Special Education District (NSSED) became the administrative and lead agency for the Northeastern Illinois Behavior Disorders Initiative. This Initiative is an Illinois State Board of Education (ISBE) funded discretionary grant project designed to improve outcomes for students with emotional and behavioral disabilities. The project focuses on reducing the reliance on residential placements by developing alternative, comprehensive, community-based service plans for students. In 1994, NSSED received additional support from the ISBE to fund a wraparound consultant position to continue the gains made by the three-year project. Two interagency wraparound councils were also developed to provide the structure required for collaborative interagency services. The school psychologist is a member of the Coordination Council and the Steering Committee, and is involved in the day-to-day implementation of the program. This initiative is currently in its sixth year of implementation and efficacy indicators have reflected positive outcomes for students and families. Findings have demonstrated that out-of-home placements and time spent in psychiatric hospitals have decreased. NSSED plans to measure academic outcomes of the students served as well as program satisfaction for teachers, parents, students, and agencies.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
Age	Birth-21
Grade	Preschool through post high school
Gender	20% female, 80% male

FUNDING SOURCES

External grants (education, child welfare, mental health pooled funding)
Funded with special education funds
Funded as non-special education support services
State agency initiative to support community-based system of care

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Classroom-based
Non-classroom based
Community-based
Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Self
Parent
Teacher
Multidisciplinary Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
Outside Agency

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Community interagency intake/referral process

GENERALIZATION PROCEDURES
Training in natural context
Reinforcement in other settings
Parent training
Teacher training
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Interview
Self-report
Rating scales
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Target behaviors (at-risk for more restrictive placement behaviors)
Specific problem behaviors (impulsive/aggressive)
Social problem solving skills
Academic functioning
Social skills
Emotional well-being
Reduction in risky behavior (harmful to self/others)
Self-esteem
Self-efficacy
Generalization of program effects to other settings
Maintenance of program effects
Move or transfer to less restrictive setting
Reduction in school discipline problems
Reduction in school violence
Increase in attendance rates
Increase in graduation rates
Increase in inclusion/retention in regular education
Reduction in referrals to special education
Reduction in special education placements
Lower rate of hospitalization
Community outcomes (increase inclusion in community activities)
Reduction in out-of-home placements

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Evaluation procedures
Evaluation results
Staff training
Intake and exit procedures
Goals and objectives
Description of program model
Definition of population served
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	20%
Program implementation	60%
Program evaluation	20%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Administrator
School Board Member
Community Mental Health Agency
Paraprofessionals
Parents
Program Recipients
Peers
Community Members

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION

Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level II.	Risk reduction,
Level III.	Early intervention
Level IV.	Treatment

INDIANA (IN)

Home-School Program
School City of Hobart

Nancy Starewicz, M.Ed., NCSP
Program Coordinator
1401 Alabama Street
Hobart, IN 46342
219-942-9902 (Phone)

PROGRAM DESCRIPTION

The goal of the Home School Program is successful completion of school for all children. The program offers alternative materials and ideas to teachers, parents, and students facing problems. There are four components of the program: (a) school counseling curriculum to provide students with knowledge of normal growth and development; (b) individual planning to help students formulate their educational, occupational, and personal goals and plans; (c) Responsive Services to assist students needing counseling, consultation, referral, or information; and (d) System Support to support the school system as a whole. The school psychologist began working on home-school activities over six years ago. She was involved in the design, implementation, and evaluation of the Home-School Program based on the Indiana Developmental School Counseling Model. Since the program began, there has been a tremendous increase in the number of phone calls and requests for assistance. Teachers and parents have been very receptive to the information they have received.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school

POPULATION

#students/clients	400 per year
Age	5-12
Grade	K-5
Gender	25% female, 75% male
Racial/ethnic composition	
African American	1%
Caucasian	99%

FUNDING SOURCES

School funded
Funded as non-special education support services

PROGRAM GOALS

Enhance social competence
Increase self-esteem
Reduce referrals to special education
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Foster appropriate expression of emotions
Crisis intervention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Generalization of program effects

PROGRAM IMPLEMENTATION

FORMAT
Individual
Large group
Classroom-based
Non-classroom based
School-wide

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Self
Parent
Teacher
Multidisciplinary Team
Prereferral Intervention Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
School Discipline Officer
Outside Agency

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Multiple levels of screening
Standardized tests
Interviews

CRITERIA FOR TERMINATION
Complete specified program

GENERALIZATION PROCEDURES
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Parent training
Teacher training
Implementation by multiple facilitators/educators
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Rating scales
Written evaluations by teachers and parents

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Specific problem behaviors (Attention Deficit Disorder)
Academic functioning
Social skills
Reduction in risky behavior

WRITTEN MATERIALS AVAILABLE

Description of program design
Curriculum
Evaluation procedures
Evaluation results
Goals and objectives
Description of program model

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	20%
Program implementation	70%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Nurse
School Administrator
Parents
Program Recipients

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention

KENTUCKY (KY)

Resolving Conflicts in Fayette County Public Schools: A Positive Approach
Fayette County Public Schools

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Title IV Consultant (Safe and Drug Free Schools)
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Safe and Drug Free Schools Program
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PROGRAM DESCRIPTION

Fayette County Public Schools (FCPS) began a conflict resolution program in August 1991 to help students and teachers develop a new awareness and willingness to examine and change conflict response behaviors. The program has received support from the business community as well as the University of Kentucky Mediation Center and College of Law. The purpose of the Conflict Resolution and Peer Mediation program is to foster a climate within the schools that is cooperative and conducive to learning. The six stages of implementation are: (a) Professional Development; (b) Student Skill Development; (c) Promotion; (d) Mediator Training; (e) Monitoring and Maintenance; and (f) Community Involvement. School psychologists have been involved with all aspects of program design, implementation, and evaluation. School psychologists serve as consultants to train counselors, staff members, peer mediators, and administrators. This training provides the school with the information to maintain and implement the program on their own. School psychologists also continue to support and consult with the schools, when necessary. Positive outcomes at the individual school level have included:

1. Schools report over 90% resolution rate in the past five years.
2. Feedback from student evaluations have always been extremely positive.
3. Parent feedback has been positive and supportive.
4. Teachers report improved personal conflict resolution skills.
5. Principals and associates report using mediation techniques during discipline conferences.
6. Counselors report using mediation strategies with groups.
7. Within the curriculum, conflict resolution activities are being used for portfolio writing and have been infused into art and music.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
#students/clients	33,000
Age	5-18
Grade	Elementary through high school
Gender	51% female, 49% male
Racial/ethnic composition	
African American	21%
Asian	2%
Caucasian	1%
Hispanic	74%
Native American	1%
West Indies	1%
Other	1%

FUNDING SOURCES
External grants (federal government)
School funded
Other (Urban County Government, Neighborhood Association)

PROGRAM GOALS
Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Violence prevention
Dropout prevention
Improve academic functioning

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Large group
Classroom-based
Non-classroom based
School-wide

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)
Collaboration with other agencies

REFERRAL SOURCES
Self
Parent
Teacher
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Discipline Officer
Outside Agency

CRITERIA FOR TERMINATION
Direct service ends when a school becomes self-sufficient. Consultation and teacher training are available on an as-needed basis

GENERALIZATION PROCEDURES
Training in natural context
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Training in multiple settings
Teacher training
Implementation by multiple facilitators/educators
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Self-report

OUTCOMES THAT ARE EVALUATED
Social problem solving skills
Reduction in school discipline problems
Reduction in school violence
Referrals to mediation, successful outcome of mediation

WRITTEN MATERIALS AVAILABLE
Goals and objectives
Description of program model

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program design/planning	20%
Program implementation	70%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Certified Social Worker
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Administrator
Community Mental Health Agency
Parents
Peers
Community Members

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on program efficacy
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION
Program acceptability
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention

Henderson County Child/Victim Task Force, Inc.
Henderson County Children's Advocacy Center
Henderson County Schools

Laura McGrail
School Psychologist
605 North Main Street
Henderson, KY 42420
502-826-4112 (Phone)
502-831-5016 (Fax)

PROGRAM DESCRIPTION

The Henderson County Child/Victim Task Force, Inc. is a non-profit agency formed by concerned citizens for the purpose of preventing child abuse and family violence in all of its forms and to promote interagency collaboration to improve services to child victims and their families in the Henderson, Kentucky area. Since its inception in April 1993, the Task Force has grown to employ two full-time staff members, three part-time staff members, and has a volunteer staff of thirty. The Task Force staff and programs are housed in the Henderson County Children's Advocacy Center which was established through Community Development Block Grant funds allocated by the Henderson City Commission. The Advocacy Center sponsors the following programs: (a) Task Force Executive Director; (b) Victim's Advocate and services; (c) Court-Appointed Special Advocates (CASA) program; (d) Crisis Child Care Nursery and staff; (d) Secretary-Receptionist; (e) Rape Victim's Service counselor; (f) a Parent Resource Library; (g) Child Abuse Multidisciplinary Planning Team; and (h) a child-centered interviewing room used by abuse investigative teams comprised of law enforcement officers and social workers. The Task Force sponsors positive parenting programs, child abuse prevention programs for parents and students, a counseling group for non-offending parents, and community awareness programs. A school psychologist was instrumental in organizing this agency and served as President of the Board of Directors for the first three years of operation. The school psychologist donates her own time to design, implement and evaluate the program.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Community social service agency

POPULATION

# students/clients	581
Age	Birth-adult
Gender	50% female, 50% male

Racial/ethnic composition

African American	14%
Asian	3%
Caucasian	80%
Hispanic	2%
Native American	1%

FUNDING SOURCES

External grants (National Court Appointed Special Advocates, Kentucky State Attorney General's Office)
Fund Raising

PROGRAM GOALS

Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Parental involvement
Reduce trauma of victimization

PROGRAM IMPLEMENTATION

FORMAT
Individual
Non-classroom based
Community-based
Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Multidisciplinary team
Outside agencies

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Child victimization
Families at-risk for child victimization

CRITERIA FOR TERMINATION
Complete specified program
Judge terminates CASA involvement

GENERALIZATION PROCEDURES
Parent training
Teacher training

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Interview
Self-report
Records of service delivery

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Academic functioning
Emotional well-being
Self-esteem
Reduction in school discipline problems
Reduction in school violence
Increase in attendance rates

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program design/planning	10%
Program implementation	80%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Certified Social Worker
Certified Counselor
Regular Education Teachers
Special Education Teachers
Parents Community Members

EMPIRICAL BASE
Research on program efficacy
Research on risk and protective factors

PROGRAM EVALUATION
Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention

Youth Assistance Model
Jefferson County Public Schools
Safe and Drug Free Schools

Dorothy Brock, Ph.D.
School Psychologist
Jefferson County Public Schools
Safe and Drug Free Schools
Old Male Educational Center
911 South Brook Street
Louisville, KY 40203
502-485-3260 (Phone)
502-485-3611 (Fax)

PROGRAM DESCRIPTION

The Youth Assistance Model is a collaboration between Jefferson, Henderson, and Christian Counties in Kentucky. This model was established to address issues impacting adjudicated youth returning to these school districts from state treatment facilities. The goal of this project is to address issues of pro-social bonding and student success. As a student returns from a state facility and enrolls in a local school, he/she is connected with an adult mentor. The responsibility of the adult mentor is to establish a positive social relationship, provide academic assistance, and provide recreational opportunities. The school psychologist was involved in the design, implementation, and evaluation of this program. After nine months, 77 students have been released from state facilities and re-entered into Jefferson County schools. Thirty-three percent of those students are still attending school. The University of Kentucky and the Kentucky Department of Education have provided consultation and technical support. Additional program data are currently being analyzed by the University of Kentucky.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
# students/clients	77
Age	14-18
Grade	Middle school, high school
Gender	2% female, 98% male
Racial/ethnic composition	
African American	60%
Caucasian	40%

FUNDING SOURCES

Title IV Safe and Drug-Free schools and Community Act
Targeted Drug and Violence Funds

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Classroom-based
Non-classroom based/camp
Community-based
Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Outside agency
Treatment facilities/camps

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Behavioral checklists
Standardized tests
Interviews
Archival records

CRITERIA FOR TERMINATION
Complete specified program
Deemed inappropriate for program-not adjudicated
Graduation/GED
Arrested/new charges
Withdrawn from school

ATTRITION RATE: 60% of adjudicated youth never enrolled or withdrew from the program

GENERALIZATION PROCEDURES
Teaching self-monitoring or verbal mediators
Parent training
Teacher training
Drug and alcohol re-education/support

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Self-report
Rating scales
Standardized tests
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Specific problem behaviors (delinquent)
Social problem solving skills
Academic functioning
Emotional well-being
Reduction in risky behavior (remain out of court system, off streets)
Generalization of program effects to other settings
Maintenance of program effects
Move or transfer to less restrictive setting
Reduction in school discipline problems
Reduction in school violence
Increase in attendance rates
Increase in graduation rates
Community outcomes (decrease drug use, delinquency)

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Program guide for implementation
Intervention techniques
Evaluation procedures
Evaluation results
Staff training
Goals and objectives
Theoretical-empirical foundation
Description of program model
Definition of population served
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	33%
Program implementation	33%
Program evaluation	33%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Community-Based Social Workers
Counselor Liaison
School Administrator
School Board Member
Paraprofessionals
Community Members
Parent Members
Judges
Prosecutor
Juvenile Justice

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

LOUISIANA (LA)

LaFourche Parish School Based Mental Health Program
LaFourche Parish School Board

Christopher L. Wilmoth
Project Coordinator
LaFourche Parish School Board
P. O. Box 879
Thibodaux, LA 70302
504-447-8181 (Phone)
504-446-1577 (Fax)

PROGRAM DESCRIPTION

The LaFourche Parish School Based Mental Health Program provides intervention, consultation, and assessment for students. Program objectives include improved interpersonal skills to manage conflict situations, improved specific social competencies and prevention of more restrictive placement. There are three interconnected programs: Discrete Planned Intervention (targeted interventions for students with emotional/behavioral disabilities at-risk of more restrictive placement), Day Treatment (therapeutic classroom for special education students at-risk out of home and/or out of school placement, or students returning to school from hospitalizations in need of a transitional placement), and School-Based Psychiatric Clinic (school-based psychiatric intervention in conjunction with the community mental health clinic for students who have not responded to non-medical interventions). A fourth program provides mental health services to preschool youngsters enrolled in the local Head Start Centers (a licensed psychologist and/or an intern work with parents and children on social competencies and problem behavior(s) that may represent barriers to future least restrictive placement). The school psychologist provides intervention planning/service, consultation, assessment, and evaluation of program effectiveness for assigned students. The multiple school-based mental health options have reduced the number of students removed from school due to behavioral difficulties secondary to unmet needs for mental health services. Outcome measures reflect a decrease in placement of E/BD students in self-contained environments and increase in inclusive placements for E/BD students: (a) maintenance of at-risk students with active psychiatric needs on regular school campuses with no attrition to date; and (b) decrease in hospitalizations of students identified with chronic psychiatric problems.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school, community mental health agency

POPULATION

# students/clients	105
Age	6-20
Grade	Kindergarten through high school
Gender	15% female, 85% male
Racial/ethnic composition	
African American	41%
Caucasian	56%
Native American	3%

FUNDING SOURCES

School funded
Funded with special education funds
Community Mental Health Center In-kind
Interagency agreement)

PROGRAM GOALS

Enhance social competence
Increase participation in regular education
Prevent placement in more restrictive setting
Increase social problem solving skills
Crisis intervention
Violence prevention
Support school transitions
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Classroom-based
Non-classroom based
District-wide

COMPONENTS

Staff training
Ongoing consultation with program staff
Obtain written consent
School psychology internship opportunity

REFERRAL SOURCES

Mental Health Support Staff (Psychologist, Counselor, Social Worker)
Community Mental Health Center

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY

Direct observation
Behavioral checklists
Standardized tests
Interviews
Curriculum-based measures

CRITERIA FOR TERMINATION

Meet outcome criteria
Other (no longer considered at risk)

ATTRITION RATE: <10% (Discrete Planned Intervention, Day Treatment)
0% (School-Based Psychiatric Clinic, Preschool Program)

GENERALIZATION PROCEDURES

Training in natural context
Teaching self-monitoring or verbal mediators
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES

Observation
Interview
Rating scales
Anecdotal records
Individualized education plan

OUTCOMES THAT ARE EVALUATED

Generalization of program effects to other settings
Move or transfer to less restrictive setting
Reduction in school discipline problems
Reduction in school violence
Increase in inclusion/retention in regular education

WRITTEN MATERIALS AVAILABLE

Description of program design
Program guide for implementation
Intake and exit procedures
Description of program model
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	5%
Program implementation	90%
Program evaluation	5%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Counselor
Special Education Teachers
Paraprofessionals
Parents

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy

PROGRAM EVALUATION

Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level IV. Treatment

MASSACHUSETTS (MA)

Child Witness to Violence Project (CWVP) Boston City Hospital

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maxineweinreb@msn.com.

PROGRAM DESCRIPTION

The Child Witness to Violence Project (CWVP) is a counseling, advocacy, and outreach project that targets young children who witness violence. This project was established in 1992 to serve the needs of hidden victims of violence, that is, children who are bystanders to community and domestic violence. CWVP is staffed by a multi-cultural, multi-lingual staff of social workers, psychologists, early childhood specialists and a consulting child psychiatrist. It is run under the auspices of the Department of Developmental and Behavioral Pediatrics at Boston Medical Center. CWVP provides counseling and advocacy services to young children (six years and under) who have witnessed violence on the street or in the home. In the program, children use drawings, dramatic play and storytelling to express their feelings. A school psychologist was involved in development, implementation and evaluation of this program. The school psychologist provides school consultation, trains teachers and mental health professionals, and offers treatment services to children. In a study conducted in the outpatient pediatric clinic at Boston Medical Center, 115 mothers were interviewed about the violence to which their children were exposed. One in ten children had witnessed a knifing or shooting by the age of six. Half of these children witnessed violence in the home; half in the community. Of the mothers, one in five were victims of severe violence. Referrals to CWVP come from a wide variety of sources, including the police, health care providers, Head Start and other early childhood programs, schools, attorneys, shelters for battered women, and court-sponsored victim services programs. Evaluation of program effectiveness is currently in progress.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Hospital

POPULATION

# students/clients	160
Age	2 to 8

FUNDING SOURCES

External grants
Funding from private agencies

PROGRAM GOALS

Increase self-esteem
Reduce referrals to special education
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Individualized therapeutic goals

PROGRAM IMPLEMENTATION

FORMAT
Community-based (hospital setting)
School consultation

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Parent
Teacher
Multidisplinary Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
Outside Agency
Police

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Interviews

CRITERIA FOR TERMINATION
Meet outcome criteria
Deemed inappropriate for program

GENERALIZATION PROCEDURES
Parent training
Teacher training
Implementation by multiple facilitators/educators
Booster or follow-up sessions
National training for law enforcement, courts, medical personnel

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Interview
Self-report
Rating scales

OUTCOMES THAT ARE EVALUATED
Specific problem behaviors (violence)
Community outcomes (reduction in PTSD symptoms)

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program design/planning	10%
Program implementation	80%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Certified Social Worker
Certified Counselor
Special Education Teachers
Pediatrician
Consulting Child Psychiatrist

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

Color War-Cooperative Education Program
Woburn Public Schools

Sara-Fay Tarlin
Department of Special Education
55 Locust Street
Woburn, MA 01801
617-937-8226 (Phone)
617-932-0668 (Fax)
starlin@aol.com

PROGRAM DESCRIPTION

Color War-Cooperative Education program is a cooperative education initiative that was created for children at Joyce Middle School in the Woburn Public School System. This program is intended to increase academic achievement, motivation, and positive classroom behavior. The school psychologist developed the program and presented the idea to the teachers. One eighth grade science teacher implemented the program. The program has been used in eight classes over three years. The students and the teacher have participated in the program evaluation and suggested modifications. Homework completion rate is 98 percent and test scores are improving.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
# students/clients	102
Age	12-15

Grade	Middle school
Gender	49% female, 51% male
Racial/ethnic composition	
Caucasian	98%
Other	2%

PROGRAM GOALS

Enhance social competence
Reduce referrals to special education
Increase participation in regular education
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Increase self-efficacy
Improve academic functioning
Risk reduction

PROGRAM IMPLEMENTATION

FORMAT
Large group
Classroom-based

COMPONENTS
Ongoing consultation with program staff

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Self-report
Standardized tests

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Target behaviors (class attentiveness, homework production, test scores)
Specific problem behaviors (class attentiveness, homework production, test scores)
Academic functioning
Reduction in risky behavior
Self-esteem
Reduction in school discipline problems
Reduction of referrals to special education

WRITTEN MATERIALS AVAILABLE

Description of program design
Program guide for implementation
Evaluation results
Goals and objectives
Description of program model
Definition of population served

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program design/planning	90%
Program implementation	5%
Program evaluation	5%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Regular Education Teachers
Program Recipients
Peers

THEORETICAL BASE
Multiple

PROGRAM EVALUATION
Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION
Level I. Prevention

Peer Mediation Program
Natick High School

Terry Davis, Ed.D.
School Psychologist
9-3 Drake Circle
Walpole, MA 02081
508-660-8986 (Phone)
508-651-7145 (Fax)
TDAVIS93@aol.com

PROGRAM DESCRIPTION

The Peer Mediation Program assists students to settle disputes in non-violent ways. It is a form of conflict resolution which includes use of trained student mediators as neutral third parties to help other students work together to create a resolution for their disputes. The student peer mediators encourage constructive communication, help students take responsibility for their actions, and clarify their needs and feelings. The goal of the mediation is to arrive at an agreement that is written and signed by all parties. Mediation has been shown to be an effective tool in resolving conflicts such as family issues, peer conflicts, authority issues, and harassment. The program has helped to reduce absenteeism, suspensions, violence, truancy, and vandalism. Participants claim that conflict resolution skills have helped them in their daily interactions with others at home and at school. The school psychologist consulted on the design and implementation of the program and also participated in training and mediation sessions. During the 1996-1997 school year, there were 54 referrals to the Peer Mediation Program. Fifty mediations were held with successful results. In the other 4 cases, students refused to participate in the mediation process.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school

POPULATION

# students/clients	115
Age	14-18
Grade	High school
Gender	50% female, 50% male
Racial/ethnic composition	
African American	17%
Asian	3%
Caucasian	70%
Hispanic	10%

FUNDING SOURCES

External grants (Department of Education)
School funded
Funded as non-special education support services
Massachusetts Department of Education Health Grant
Natick Public Schools

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Risk reduction
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Non-classroom based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Self
Teacher
School discipline officer

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Interviews

CRITERIA FOR TERMINATION
Meet outcome criteria

ATTRITION RATE: 0%

GENERALIZATION PROCEDURES
Training in natural context
Teaching self-monitoring or verbal mediators

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Self-report
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Attitudes/beliefs
Target behaviors (fighting or threats)
Specific problem behaviors (fighting or threats)
Social problem solving skills
Social skills
Reduction in risky behavior (fighting)
Reduction in school discipline problems
Reduction in school violence

WRITTEN MATERIALS AVAILABLE

Description of program design
Program guide for implementation
Evaluation results
Staff training
Goals and objectives
Description of program model
Definition of population served

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)
Program design/planning 70%
Program implementation 30%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Certified Counselor
Peers

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION

Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention

Transfer Program
Wellesley High School

Roslyn B. Coleman, Ed.D., NCSP
Psychologist
Dr. Alison Mountford, Psy.D.
50 Rice Street
Wellesley Hills, MA 02181-6099
617-446-6290 (Phone)
617-237-6004 (Fax)

PROGRAM DESCRIPTION

Wellesley High School offers a program for new students who transfer from other schools within Massachusetts, other states in the U.S., or other countries. Transfer peer leaders, who may or may not be new to Wellesley High, want to make the transition to a new school easier for newcomers. Transfer peer leaders play a variety of roles. As members of the weekly groups, they help the group run more smoothly and encourage new members to become involved in the discussion. As leaders in the transfer program, they help plan and carry out activities to help new students get acquainted with school geography and culture at the beginning of the school year and as new students enroll during the year. As electives during the school day, transfer groups provide an important service to the Wellesley High School Community and are a cost effective, proactive way to encourage a healthy teenage community. The school psychologist co-leads the groups with school psychology interns. The team of school psychologists modify, plan, implement, and evaluate the program.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
# students/clients	80
Age	14-18
Grade	High school
Gender	50% female, 50% male
Racial/ethnic composition	
African American	2%
Asian	5%
Caucasian	85%
Hispanic	3%
Middle Eastern	5%

FUNDING SOURCES

School funded (part of the school psychologist's job responsibilities)

PROGRAM GOALS

Enhance social competence
Increase self-esteem
Reduce referrals to special education
Prevent placement in more restrictive setting
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Small group
Classroom-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)
Other

REFERRAL SOURCES
Self
Parent
Teacher
Multidisciplinary Team
Prereferral Intervention Team
Mental Health Support Staff (Psychologist, Guidance Counselor, Social Worker)
New Students

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Interviews
Other (new or transfer students)

ATTRITION RATE: 2%

GENERALIZATION PROCEDURES
Reinforcement in other settings

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Questionnaire

OUTCOMES THAT ARE EVALUATED
Attitudes/beliefs
Group observations, program satisfaction

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Program guide for implementation
Curriculum
Evaluation procedures
Evaluation results
Goals and objectives

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	5%
Program implementation	90%
Program evaluation	5%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
School Psychology Interns

THEORETICAL BASE

Multiple

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level II.	Risk reduction

MINNESOTA (MN)

Collaborative Evening Parent Training Classes
Stillwater Area Schools

Paula Laidig
School Psychologist
Stonebridge Elementary School
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Stillwater, MN 55082
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612-351-9345 (Fax)
laidig@aol.com

PROGRAM DESCRIPTION

Six Collaborative evening Parent Training Classes were provided for parents of at-risk and behaviorally disordered children and youth to address two needs: (a) parents, schools, and community agencies needed to collaborate to most effectively change child behavior; and (b) parents of difficult-to-manage children and youth lacked sufficient information, skills and support. Parents were invited to attend weekly two-hour sessions that provided training, support, and dinner (participants were also reimbursed for transportation and baby-sitting fees). The sessions were co-facilitated by school psychologists and community mental health professionals. Follow-up in home training/support also was offered. The school psychologist was involved in the design, implementation, and evaluation of this program. Specifically, the school psychologist (a) developed the curriculum for the parent training program; (b) co-facilitated the evening parent training classes; and (c) conducted data analysis, report writing, and grant writing.

On the first and last night of classes, parents rated, on a Likert-type scale: (a) their perceptions of their children's behavior; (b) their knowledge of strategies to change behavior; (c) the effectiveness of the strategies; and (d) their opinion of the program components. Comparing the pre- and post- intervention questionnaires, the averages scores on all of the questions showed positive change. Increases were reported in knowledge of behavior change strategies and effectiveness in managing children's behavior. On the post-intervention questionnaire parents continued to rate their children's behavior as a serious problem, with some decrease of severity. Parents reported that they would attend a follow-up series of meetings and would recommend the classes to a friend. The co-facilitators completed a qualitative questionnaire at the end of the classes. The results indicate that they (a) found the materials to be basic enough to generalize to most parents; and (b) felt that most of the parents benefited from the curriculum materials and support from other parents and co-facilitators. All had positive comments regarding the experience and were interested in co-facilitating the classes in the future.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school

POPULATION
Racial/ethnic composition
Caucasian 100%

FUNDING SOURCES

External grants
In-kind school district contributions

PROGRAM GOALS

Teach specific social skills
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Crisis intervention
Violence prevention
Parental involvement
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Large group
Non-classroom based
Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Self
Teacher
Multidisciplinary team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
Outside agency
Administrators

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Behavioral checklists
Interviews

CRITERIA FOR TERMINATION
Complete specified program

GENERALIZATION PROCEDURES
Teaching self-monitoring or verbal mediators
Parent training
Implementation by multiple facilitators/educators
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Self-report
Rating scales

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Target behaviors (parenting techniques)
Specific problem behaviors
Reduction in risky behavior (rule-breaking)
Generalization of program effects to other settings

WRITTEN MATERIALS AVAILABLE

Description of program design
Program guide for implementation
Curriculum
Intervention techniques
Evaluation procedures
Evaluation results
Goals and objectives
Theoretical-empirical foundation
Description of program model
Definition of population served

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	15%
Program implementation	75%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
School Administrator

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

Together for Children
Anoka-Hennepin School District #11

Sally A. Baas
School Psychologist
8989 Sycamore Street- NW
Coon Rapids, MN 55433
612-422-5877 (Phone)
612-422-5542 (Fax)

PROGRAM DESCRIPTION

The Together for Children's mission is to develop a plan to coordinate community resources to ensure a safe healthy environment for all children. The program intends to create a community response to meet the educational needs of all children, including those with emotional needs. The school psychologist was the Committee Chairperson for Wrap Around services, editor of the newsletter, and a member of the project evaluation and program design teams.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school, community mental health agency, corrections, county case managers, community agencies, city council, legislators

POPULATION

Age	5-21
Grade	Preschool through high school
Gender	50% female, 50% male
Racial/ethnic composition	
African American	2%
Asian	2%
Caucasian	94%
Hispanic	1%
Native American	1%

FUNDING SOURCES

External grants (United Way)
School funded
County agency involvement

PROGRAM GOALS

Enhance social competence
Increase self-esteem
Reduce referrals to special education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Increase social problem solving skills
Increase self-efficacy
Violence prevention
Dropout prevention
Support school transitions
Parental involvement
Risk reduction

PROGRAM IMPLEMENTATION

FORMAT
Small group
Large group
Classroom-based
Non-classroom based
District-wide
Community-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Self
Parent
Teacher
Multidisciplinary Team
Prereferral Intervention Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
School Discipline Officer
Outside Agency
Counselors

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Multiple levels of screening
Standardized tests
Interviews
Curriculum-based measures

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Self-report
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Specific problem behaviors
Emotional well-being
Reduction in risky behavior
Self-efficacy
Maintenance of program effects
Move or transfer to less restrictive setting
Reduction in school discipline problems
Reduction in school violence
Reduction in referrals to special education
Reduction in special education placements
Community outcomes

WRITTEN MATERIALS AVAILABLE

Description of program design
Evaluation procedures
Procedures for insuring generalization of program effects
Goals and objectives
Theoretical-empirical foundation
Description of program model
Definition of population served

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	20%
Program implementation	70%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Nurse
School Administrator
School Board Member
Community Mental Health Agency
Paraprofessionals
Parents
Program recipients
Peers
Community members

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on risk and protective factors

PROGRAM EVALUATION

Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk Reduction
Level III.	Early intervention
Level IV.	Treatment

MONTANA (MT)

Intervention Assistance Program
Fairfield Elementary

Tammy Lacey
K-8 Principal
P.O. Box 99
Fairfield, MT 59436
406-467-2425 (Phone)
406-467-2554 (Fax)

PROGRAM DESCRIPTION

The Intervention Assistance Process is a collaborative, problem-solving, team approach used to help meet the challenges that today's students bring to the educational setting. A core team of staff members is trained in problem-solving, consulting, and intervention generating. Ancillary team members are added as necessary depending on the challenge exhibited. The team is accessed whenever a student exhibits a challenge that cannot be met by the usual means. The process consists of defining the challenge, setting goals, brainstorming interventions, choosing an intervention, arranging for support and follow-up, and evaluating the intervention. The purpose of the Intervention Assistance Process is to reduce the number of inappropriate special education referrals which in turn reduces the amount of psychological assessment time needed. Additionally, through the school psychologist's involvement, early intervention efforts prevent students' difficulties from worsening thereby requiring less intervention in the long run.

The school psychologist is involved in program design, implementation, and evaluation. Specifically, the school psychologist designed the Intervention Assistance Program by helping the school conduct a needs assessment, secure resources, and training selected staff members. She also assists in implementation of the program by participating as a team member in behavioral cases. The school psychologist evaluates individual behavioral interventions and the overall program.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
# students/clients	205
Age	3-14
Grade	Preschool through junior high school
Gender	45% female, 55% male
Racial/ethnic composition	
Caucasian	100%

FUNDING SOURCES

School funded
School mandated
Funded as non-special education support services

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Individualized goals
Increase teacher repertoire of interventions

PROGRAM IMPLEMENTATION

FORMAT
Individual
Large group
Classroom-based
Non-classroom based
School-wide
Community-based

Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Self
Parent
Teacher
Multidisciplinary Team
Prereferral Intervention Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Discipline Officer
Outside Agency
School Support Staff, Law Enforcement

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Interviews
Curriculum-based measures

CRITERIA FOR TERMINATION
Meet outcome criteria

GENERALIZATION PROCEDURES
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Parent training
Teacher training

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Target behaviors (referral behavior)
Specific problem behaviors (referral behavior)
Social problem solving skills
Academic functioning
Social skills
Emotional well-being
Self-esteem
Self-efficacy
Reduction in school discipline problems
Reduction in referrals to special education
Reduction in special education placements

WRITTEN MATERIALS AVAILABLE

The following written materials are included as part of the school district policy:

- Program guide for implementation
- Description of program design
- Description of program model
- Referral procedures

The following written material are generated for individual or group cases and are therefore unique:

- Intervention techniques
- Evaluation procedures
- Evaluation results
- Staff training
- Goals and objectives

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	50%
Program implementation	30%
Program evaluation	20%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Regular Education Teachers
Special Education Teachers
School Administrator
School Board Member
Paraprofessionals
Parents
Program Recipients
Peers

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION
Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level III.	Early intervention

Yellowstone Treatment Centers

Cynthia Paugh Shumaker, M.Ed.
School Psychologist
1732 South 72nd Street West
Billings, MT 59106-3599
406-656-2198 (Phone)
406-652-8969 (Fax)

PROGRAM DESCRIPTION

Over the past 38 years, the Yellowstone Treatment Centers/Yellowstone Academy has developed extensive programs serving seriously emotionally disturbed children and adolescents (aged 6 to 18) on its unique campus which is located on a 400-acre ranch west of Billings, MT. The continuum of care includes comprehensive assessment, outpatient services, day school/day treatment, psychiatric residential treatment, and specialty programs such as sex offender treatment, chemical dependency treatment, family and individual therapy, and experimental therapy. Residential treatment is provided in eight lodges, each with ten beds. Residents attend school at Yellowstone Academy which serves grades 1 through 12 with self-contained special education classrooms as well as a traditional high school rotation program. A highly structured, supervised, consistent treatment plan, and individual education plan is developed for each youth, whose program is reviewed on a monthly basis. All programs at Yellowstone Treatment Centers have the primary goal of returning the youth to his/her community with new skills that allow for healthy relationships and a productive life. The school psychologist participates in the initial evaluation of individuals. The psychological evaluations are used by the team in the development of individual treatment plans. The school psychologist also is involved in the design and implementation of the program.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school, private school, medical clinic, residential treatment center

POPULATION	
# students/clients	90
Age	7-19
Grade	Elementary school through high school, GED
Gender	11% female, 89% male
Racial/ethnic composition	
African American	10%
Asian	1%
Caucasian	82%
Hispanic	2%
Native American	5%

FUNDING SOURCES

External grants (Yellowstone Boys and Girls Ranch Foundation)
Funded with special education funds
Funded as non-special education support services
Medicaid
Private insurance
Juvenile court system, department of family services, resident school district special education department

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Increase participation in regular education
Reduce specific behavioral problems
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Generalization of program effects

Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Large group
Classroom-based
Non-classroom based
School-wide
District-wide
Community-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Parent
Multidisciplinary Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
Outside Agency

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Multiple levels of screening
Standardized tests
Interviews
Curriculum-based measures
Psychiatric evaluation

CRITERIA FOR TERMINATION
Meet outcome criteria
Complete specified program
Deemed inappropriate for program
Decertified by funding source

GENERALIZATION PROCEDURES
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Training in multiple settings
Parent training
Teacher training
Implementation by multiple facilitators/educators
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Self-report
Rating scales
Standardized tests
Anecdotal records
Long range follow-up (after care assessment)

OUTCOMES THAT ARE EVALUATED
Attitudes/beliefs
Target behaviors (verbal and physical aggression)
Specific problem behaviors (withdrawal, passive-aggressive, off-task)
Social problem solving skills
Academic functioning
Social skills
Emotional well-being
Reduction in risky behavior (substance abuse, self-abuse, suicidal ideation, anorexia)
Self-esteem
Self-efficacy
Generalization of program effects to other settings
Maintenance of program effects
Move or transfer to less restrictive setting
Reduction in school discipline problems
Reduction in school violence
Increase in attendance rates
Increase in inclusion/retention in regular education
Reduction in special education placements
Lower rate of hospitalization
Community outcomes (safety in the community)

WRITTEN MATERIALS AVAILABLE

Description of program design
Intervention techniques
Evaluation procedures
Staff training
Description of program model
Definition of population served
Eligibility criteria

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

Program design/planning	40%
Program implementation	40%
Program evaluation	20%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Administrator
School Board Member
Community Mental Health Agency
Paraprofessionals
Parents
Program Recipients
Peers

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION

Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

NEBRASKA (NE)

Site-Based School Community Facilitator Gering Public Schools

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Gering, NE 69341
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rboice@gering.esu14.k12.ne.us

PROGRAM DESCRIPTION

Gering Public Schools has taken a strong approach toward serving at-risk students through the implementation of a School-Community Facilitator project. An evaluation of the district's traditional refer-test-place model revealed that many students' needs were not being adequately addressed, teachers were requesting additional support, and the administration was frustrated. The School Community Facilitator project was developed and implemented to address these specific concerns. Teachers and parents receive services such as skills training and consultation. The school psychologist, as facilitator, provides early prevention services, interventions and other appropriate services to students. The program's efficacy is being externally evaluated by Dr. Ellis Copeland, Professor, University of Northern Colorado, Greeley, Colorado. He notes that "initial results have been impressive as all school personnel consider the change to be superior to the traditional model". A review of the project indicated that the teachers all seemed positive toward the project and felt it made a difference with students.

Dr. Max McFarland, Program Director, School Psychology Training, University of Nebraska, Kearney, Nebraska stated that approximately two and one half years ago a team of external evaluators was created by the Gering schools for the purpose of conducting comprehensive program evaluation. The evaluation focused on the efficacy of the delivery of education services which included general education, special education services and psychological services.

1. Services are coordinated to provide maximum support possible to students at their point of need.
2. Services have taken on more of a problem solving orientation and are expanding from the traditional refer-test-place model.
3. Classroom teachers report a tremendous increase of support to devise/implement pre-referral academic and/or behavioral interventions and perceive empowerment as credible collaborative participants in team problem solving efforts.
4. Preliminary data strongly suggest how efficaciously this model is addressing the very needs/concerns that were identified as priorities in the comprehensive program evaluation conducted two and one half years ago.
5. It is the only implementation of such a model that I am aware of in the state of Nebraska. This type of experimentation with alternative delivery systems is essential for our state.
6. The unique blending of funding which underlies this model is truly exemplary. In blending special education and general education funding such psychological services truly becomes services for ALL children and services provided to address student and district needs at a proactive-preventative level.

Randy Butcher, Consultant, Nebraska Department of Education, Special Education Division, notes the Gering Public Schools has taken a strong approach toward serving at-risk students through the implementation of a School-Community Facilitator project. The implementation of this program is child-centered and addresses many areas of need in early intervention which increases the students chances of success and progress. This program should be considered a model program which other schools could use to design an effective process to meet all students individual needs.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school, Northfield Elementary
POPULATION	
# students/clients	360
Age	Birth-13
Grade	Preschool, elementary school

Gender	60% female, 40% male
Racial/ethnic composition	
African American	1%
Caucasian	77%
Hispanic	20%
Native American	2%

FUNDING SOURCES

External grants (Department of Education, Nebraska Department of Education)

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Reduce referrals to special education
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem-solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate service
Expression of emotions
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT

Individual
Small group
Large group
Classroom-based
Non-classroom based
School-wide
Home-based

COMPONENTS

Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES

Self
Parent
Teacher
Multidisciplinary Team
Pre-referral Intervention Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
School Discipline Officer
Outside Agency

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY

Direct observation
Behavioral checklists
Multiple levels of screening
Standardized tests
Interviews
Curriculum-based measures

CRITERIA FOR TERMINATION

Meet outcome criteria
Complete specified program
Deemed inappropriate for program

GENERALIZATION PROCEDURES

Teaching self-monitoring or verbal mediators
Training in multiple settings
Parent training
Teacher training
Implementation by multiple facilitators/educators
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES

Observation
Interview
Self-report
Rating scales
Standardized tests
Anecdotal records

OUTCOMES THAT ARE EVALUATED

Target behaviors
Specific problem behaviors (red flags)
Social problem solving skills
Academic functioning
Social skills
Emotional well-being
Reduction in risky behavior (red flags)
Self-esteem

Self-efficacy
Move or transfer to less restrictive setting
Reduction in school discipline problems
Reduction in school violence
Increase in attendance rates
Increase in graduation rates
Increase in inclusion/retention in regular education
Reduction in referrals to special education
Reduction in special education placements

WRITTEN MATERIALS AVAILABLE

Description of program design
Program guide for implementation
Evaluation procedures
Evaluation results
Intake and exit procedures
Description of program model
Eligibility criteria
Referral procedures

*For a nominal fee, individuals and organizations could obtain a copy of project, evaluation, and research

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	10%
Program implementation	75%
Program evaluation	15%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Regular Education Teachers
Special Education Teachers
School Nurse
School Administrator
School Board Member

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

NEW HAMPSHIRE (NH)

Facilitating Integrated Interagency Services for Children with Emotional or Behavioral Disorders
Special Education Department, Nashua, New Hampshire Public Schools

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PROGRAM DESCRIPTION

Nashua Public Schools implemented a project to better provide an array of services to children with emotional or behavioral disorders (EBD). Project goals were to:

1. Increase interagency collaboration among educational, community mental health, and recreational facilities in the treatment and case management of children and adolescents with EBD.
2. Increase the availability, quality, and ease of access of community mental health and recreational activities for children and adolescents with EBD and their families, particularly those from inner city, disadvantaged, and minority backgrounds; thereby improving their self-esteem, locus of control and behavior.
3. Improve the problem solving skills, parenting skills, and networking ability of parents of children with EBD through interagency parent support group and family therapy participation.

School psychologists were involved in each aspect of the project: (a) grant development; (b) program consultation and coordination; (c) co-leading parent support groups with community mental health agency staff; (d) participating in wrap-around planning committees; (e) training school and recreational staff; (f) providing psychological services; (g) summer and after-school programming; and (h) observation and feedback to children about their behavior, social skills, and alternative choices.

The project used an outcome-oriented evaluation plan that focused on the benefits to individual children, adolescents, and their families. Evaluation measures included: (a) demographic information; (b) functioning of the children with EBD who participated in the after-school, summer, and/or family therapy programs; (c) parent satisfaction; and (d) staff satisfaction. A 1993-1994 project report indicated that 48% of the targeted students moved out of the district. Approximately one-third of the target population participated in at least one recreational program. Parent support groups were successful for attendance. The parents' primary interest was obtaining knowledge on how to better advocate for their children rather than learning behavior management strategies. Parents were surveyed at the endof the project regarding their overall satisfaction with the program. The return rate of the questionnaire was very low (16%), limiting the generalizability. The proposed group family therapy was not successful for a variety of reasons. Increased interagency collaboration was fostered through (a) staff training in non-violent crisis intervention and basic strategies for working with children with EBD and (b) working in teams. The demand for staff training was very high and continued throughout the project

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school

POPULATION

# students/clients	80
Age	6 to 16
Grade	Elementary through high school
Gender	20% female, 80% male

Racial/ethnic composition

African American	2%
Caucasian	95%
Hispanic (any race)	3%
Asian	2%
Other	1%

FUNDING SOURCES

External grants (U.S. Department of Education)
Schoolfunded
Schoolmandated
Funded with special education funds

Medicaid

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Large group
Classroom-based
Non-classroom based
Community-based (wrap-around)
Home-based (home visits)

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Self
Parent
Teacher
Multidisplinary Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
Outside Agency

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Multiple levels of screening
Standardized tests
Interviews
Curriculum-based measures
Other (consultation interventions)

CRITERIA FOR TERMINATION
Meet outcome criteria
Complete specified program
Attrition

GENERALIZATION PROCEDURES
Training in natural context
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Training in multiple settings
Parent training
Teacher training

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Interview
Self-report
Rating scales
Standardized tests
Student files for attendance, mainstreaming hours

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Target behaviors
Specific problem behaviors
Social problem solving skills
Academic functioning
Social skills
Emotional well-being
Reduction in risky behavior
Self-esteem
Self-efficacy
Generalization of program effects to other settings
Maintenance of program effects
Move or transfer to less restrictive setting
Reduction in school discipline problems
Reduction in school violence
Increase in attendance rates
Increase in graduation rates
Increase in inclusion/retention in regular education
Reduction in special education placements

Lower rate of hospitalization
Community outcomes

WRITTEN MATERIALS AVAILABLE

Description of program design
Definition of population served
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	5%
Program implementation	90%
Program evaluation	5%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Nurse
School Administrator
Community Mental Health Agency
Paraprofessionals
Parents
Program Recipients

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

Project DESTINY
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Keene State College

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PROGRAM DESCRIPTION

Project DESTINY is a multidisciplinary, collaborative approach designed to meet the needs of students with severe emotional disturbance or behavior disorders, by providing training and support to educators, mental health professionals, and families. Services included (a) staff development at two middle schools (grade 5-8) to enhance participants' knowledge and skills to improve services for children and youth with SED; and (b) Parent support groups in the two communities that met twice monthly during years two and three of the project. The school psychologist's role in the program included program design, implementation of team meetings and inservice training, data collection, and evaluation.

Outcome indicators were collected for over 100 teachers, 20 families, and 20 students with serious emotional disturbances, 80 students with classroom behavior problems, and 80 typically developing students by the end of the third year of the project. Educators rated themselves as increasing their knowledge and skills for students with SED, having high levels of collaboration and communication skills, and being actively involved in collaborative team meetings to develop action plans for students for two years. Student improvements were found in attendance, maintenance of acceptable grades (above C average), social skills, and inclusion in regular education classrooms. Parents gave very positive feedback concerning parent support groups and involvement in the school program during the project implementation.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public School

POPULATION

# students/clients	60
Age	11-15
Grade	Middle school
Gender	25% female, 75% male
Racial/ethnic composition	
African American	1%
Caucasian	98%
Hispanic	1%

FUNDING SOURCES

External grants (U.S. Dept. of Education, Office of Special Education and Rehabilitation)

PROGRAM GOALS

Enhance social competence
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Crisis intervention
Improve academic functioning
Parental involvement
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Small group
Large group
Non-classroom based
School-wide
Community-based
Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent

REFERRAL SOURCES
Multidisciplinary team

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Multiple levels of screening
Interviews

CRITERIA FOR TERMINATION
Meet outcome criteria

GENERALIZATION PROCEDURES
Training in natural context
Training in multiple settings
Parent training
Teacher training
Implementation by multiple facilitators/educators

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Interview
Self-report
Rating scales
Anecdotal records
Case Studies

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Academic functioning
Social skills
Reduction in school discipline problems
Increase in attendance rates

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Evaluation results
Goals and objectives
Theoretical-empirical foundation
Description of program model
Definition of population served
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	20%
Program implementation	60%
Program evaluation	20%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Administrator
Community Mental Health Agency
Paraprofessionals
Parents
Program Recipients

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy

PROGRAM EVALUATION

Program acceptability
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level III.	Early intervention
Level IV.	Treatment

NEW JERSEY (NJ)

Program for Attention Learning & Socialization (P.A.L.S.)
Edgewater Park Township Schools

John Lestino, MA
School Psychologist
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609-877-3941 (Fax)

PROGRAM DESCRIPTION

The Program for Attention Learning and Socialization (P.A.L.S.) has, from the outset, been both an individual case support program, as well as a training model for families and school staff who come in contact and work with attentionally challenged youth and children. The mission of P.A.L.S. is to combine the resources of a consortium of public schools in the Central Burlington County Region with those of a university-affiliated hospital, Children's Seashore House at the University of Pennsylvania, for the purposes of:

1. Developing programs that will enable all students to sustain attention and control their behavior more effectively;
2. Reducing the risk of students who display problems paying attention and controlling their behavior;
3. Understanding the needs of students with ADHD and related problems;
4. Designing interventions that address the academic, emotional, and social needs of students with ADHD and related problems in school, home, and neighborhood settings;
5. Encouraging school professionals to be creative and to take risks in attempting to solve the problems presented by children with ADHD.

Programs are offered on a continuum of care that ranges from prevention through intervention. Prevention services include designing classroom environments and improving instructional strategies. Risk reduction activities include designing class-wide behavior modification programs and reorganizing the playground to reduce aggression Early intervention services include teacher-designed instructional and behavioral interventions as well as home-school collaboration. Interventions include Teacher-Assistance Teams, the Pupil Assistance Committee (PAC), University consultation, and Child Study Team involvement.

School psychologists are involved in the design, implementation, and evaluation of the program. School psychologists assess attentional and behavior problems, and evaluate treatment outcomes. They collaborate with teachers to design interventions that are effective and practical.

The P.A.L.S. project has had an impact at multiple levels, including school, district, regional, state, and national. There has been overwhelming support from boards of education, superintendents, principals, and directors of special education. Professionals from the Child Study Teams have participated intensively in the project and over 67% of the faculty, since 1989, have attended workshops, seminars, and/or consultation sessions conducted by core members of P.A.L.S. teams. Since 1989, an estimated 1,500 parents have attended workshops, seminars, and/or consultation sessions conducted by core members of P.A.L.S. teams. The percent of students eligible for special education has been reduced from 20.5% in 1993 to 19.3% in 1996. It is estimated that 1,200 students have benefited directly by PALS through PAC and special education. An estimated 75% of the student body in the region has benefited indirectly from the project through their involvement with teachers and parents who have received training through P.A.L.S.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school, School-linked clinic (University-affiliated hospital)

POPULATION

# students/clients	12,197
Age	3-21
Grade	Preschool through high school
Gender	49% female, 51% male
Racial/ethnic composition	
African American	24%
Asian	5%

Caucasian	61%
Hispanic	8
Native American	1%
West Indies	1%

FUNDING SOURCES

External grants (state funding through Title IV; federal funding through IDEA)
Regional funding by 10 participating school districts (consortium)
School funded
Funded with special education funds
Funded as non-special education support services
Funding from Children's Seashore House, University of Pennsylvania

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Violence prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT

Individual
Small group
Large group
Classroom-based
Non-classroom based
School-wide
District-wide

COMPONENTS

Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES

Parent
Teacher
Pediatrician

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY

Direct observation
Behavioral checklists
Multiple levels of screening
Standardized tests
Interviews
Curriculum-based measures

CRITERIA FOR TERMINATION

Complete specified program

GENERALIZATION PROCEDURES

Training in natural context
Reinforcement in other settings
Parent training
Teacher training
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES

Observation
Self-report
Rating scales
Anecdotal records

OUTCOMES THAT ARE EVALUATED

Attitudes/beliefs
Target behaviors
Specific problem behaviors
Academic functioning
Reduction in risky behavior (aggression, disruptive behavior)
Generalization of program effects to other settings
Reduction in school discipline problems
Increase in inclusion/retention in regular education
Reduction in referrals to special education
Reduction in special education placements

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design

Program guide for implementation
Intervention techniques
Evaluation procedures
Evaluation results
Cost-benefit analysis
Staff training
Intake and exit procedures
Description of program model
Definition of population served
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	40%
Program implementation	50%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Nurse
Pediatricians in Community
School Administrator
School Board Member
Directors of Special Education
Paraprofessionals (Playground Assistants)
Parents
Program Recipients
Peers
Children's Seashore House, University of Pennsylvania

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on population needs
Research on risk and protective factors
Research on effective cognitive-behavioral strategies

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

Social Decision Making and Problem Solving Program
Department of Psychology
Rutgers University

Maurice J. Elias, Ph.D.
Professor of Psychology
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PROGRAM DESCRIPTION

The Social Decision Making and Problem Solving Program focuses on teaching students social competence skills that can be used to prevent violence, substance abuse, and related problem behaviors. It is currently being used in twenty-one states, and school districts in Australia, India and Israel. The program has been implemented with students in kindergarten through 12th grade in urban, rural and suburban settings. The program has been used with both general education and special education students. In addition, components of the training have been used in parent training sessions. The school psychologist involvement varies tremendously depending on the district. However, the program's co-founder, senior trainers and innovators are all school psychologists.
The program is approved by the National Association of Pupil Services Organization as meeting Goals 2000 Goal #7. Program efficacy research gathered over nearly two decades has revealed that, relative to children who were not participants, children involved in the programs: (a) were more sensitive to others' feelings; (b) had a better understanding of the consequences

of their behavior; (c) showed an increased ability to "size up" interpersonal situations and plan appropriate actions; (d) had higher self-esteem; (e) were seen by their teachers as displaying more positive prosocial behavior; (f) were sought out by their peers for help with problems; (g) better handled the difficult transition to middle school; (h) displayed lower than expected levels of antisocial, self-destructive, and socially disordered behavior, even followed up into high school; and (i) used what they learned in self-control, social awareness, and social decision making and problem solving lessons in situations both in and out of the classroom. Data also show that children and teachers enjoyed the program and put its principles to regular and frequent use.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school, private school, university-based
POPULATION	
# students/clients	25,000
Age	5-18
Grade	Elementary through high school
Gender	50% female, 50% male

Racial/ethnic composition

African American	20%
Asian	4%
Caucasian	70%
Hispanic	5%
Other	1%

FUNDING SOURCES

External grants
School funded
Funding from private agencies
Foundation funds, research and development grants

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent (varies)
Access additional resources (e.g., funding, staff)

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Interviews
Behavior incident reports

GENERALIZATION PROCEDURES
Training in natural context
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Training in multiple settings
Parent training
Teacher training
Implementation by multiple facilitators/educators
Booster or follow-up sessions
Use of prompts and picture cues

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Self-report
Rating scales
Standardized tests
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Target behaviors
Specific problem behaviors
Social problem solving skills
Academic functioning
Social skills
Reduction in risky behavior
Self-esteem

Self-efficacy
Generalization of program effects to other settings
Maintenance of program effects
Reduction in school discipline problems
Reduction in school violence

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Program guide for implementation
Curriculum
Intervention techniques
Evaluation procedures
Evaluation results
Staff training
Procedures for insuring generalization of program effects
Goals and objectives
Theoretical-empirical foundation
Description of program model
Definition of population served

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	30%
Program implementation/ consultation	60%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Nurse
School Administrator
Paraprofessionals
Parents
Program Recipients
Peers
Community Members

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

NEW YORK (NY)

Broad Street Teaching and Learning Center
Board of Cooperative Educational Services (BOCES)

Kevin I. Coats, Ph.D., NCSP
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518-761-0804 (Fax)

PROGRAM DESCRIPTION

The Broad Street Teaching and Learning Center (BSTLC) is a therapeutic special education day school component of Board of Cooperative Educational Services (BOCES). The program offers full-day classes during the academic year and a 6-week summer program. A comprehensive array of mental health services are provided which may include individual and group counseling, psychiatric assessment, consultation and treatment, child-focused family assessment, consultation and referrals, behavior therapy, and crisis intervention work. Special education teachers, mental health teachers, and the school psychologist work as a team to address each student's individual needs. The school psychologist is involved in program design, implementation, and evaluation. Specifically, the school psychologist acts as a consultant on system design (e.g., intake procedures, behavior management practices, development of goals), provides direct treatment services to the child and family, provides staff training (e.g., crisis training), and monitors data. An evaluation of the program was conducted by the evaluation and Research Associates for BOCES. The BSTLC 1991-1993 records show evidence of the following: (a) students have a high attendance rate; (b) all students have Individualized Educational Plans (IEP) with measurable goals and objectives, which most students accomplish each year; (c) some positive changes were seen on the report cards for the two marking periods; and (d) parents responded readily to the telephone survey and reported high satisfaction with the program. Parents indicated the major strength of the program is the ability and dedication of teachers.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: BOCES operated therapeutic day school

POPULATION

#students/clients	42
Age	5-14
Grade	Elementary school
Gender	11% female, 89% male
Racial/ethnic composition	
Caucasian	99%
Hispanic	1%

FUNDING SOURCES

External grants (federal funding agency for the education of students with disabilities)
School funded
School mandated
Funded with special education funds
Medicaid

PROGRAM GOALS
Enhance social competence
Teach specific social skills
Increase self-esteem
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Classroom-based
Non-classroom based
School-wide
Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Parent
Multidisciplinary team
Outside agency
Other (hospitals)

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Behavioral checklists
Standardized tests
Interviews

CRITERIA FOR TERMINATION
Meet outcome criteria
Deemed inappropriate for program

ATTRITION RATE: 3.5%

GENERALIZATION PROCEDURES
Teaching self-monitoring or verbal mediators
Training in multiple settings
Parent training
Implementation by multiple facilitators/educators

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Rating scales
Anecdotal records
Archival records (behavioral logs)

OUTCOMES THAT ARE EVALUATED
Attitudes/beliefs
Target behaviors
Specific problem behaviors
Academic functioning
Social skills
Emotional well-being
Reduction in risky behavior
Self-esteem
Move or transfer to less restrictive setting
Reduction in school discipline problems
Reduction in school violence
Increase in attendance rates
Lower rate of hospitalization

WRITTEN MATERIALS AVAILABLE

Description of program design
Intervention techniques
Intake and exit procedures
Description of program model
Definition of population served

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program design/planning	15%
Program implementation	80%
Program evaluation	5%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Certified Social Worker
Certified Counselor
Special Education Teachers
School Nurse
School Administrator
Child Psychiatrist
Paraprofessionals
Parents
Peers

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on program efficacy
Research on population needs

PROGRAM EVALUATION
Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION
Level IV. Treatment

Colonie Community Partnership
North Colonie Central Schools

Dr. Ted Feinberg
Senior School Psychologist
543 Loudon Road
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Newtonville, NY 12188-0708
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518-783-5904 (Fax)

PROGRAM DESCRIPTION

The Colonie Community Partnership is a joint venture that links school, community, business, law enforcement and clergy in a voluntary alliance committed to promoting healthy, viable options for adolescents. From its original inception, the partnership has expanded to eight active focus groups, each working on projects that enhance programs and services for teens. In addition, the partnership is actively exploring the construction of a major full-service community facility that will serve the purpose of centralizing resources to better meet the needs of adolescents and their families together. The school psychologist approached the Assistant Supervisor and Director of Pupil Services with the idea to examine the causes for alcohol/drug use in teens as a result of a community incident. The school psychologist is involved with program design, implementation, and evaluation. Informal observations and feedback indicates growing interest and support of the program.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Combines two public school systems (North and South Colonie), clergy, community agencies and businesses

POPULATION

# students/clients	120-250 students per evening activities
Age	12-21
Grade	Junior high, high school
Gender	30% female, 70% male

Racial/ethnic composition

African American	4%
Asian	3%
Caucasian	90%
Hispanic	1%
Native American	1%
West Indies	1%

FUNDING SOURCES

Other (contributions of money, volunteer staff time)

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce specific behavioral problems
Increase social problem solving skills
Teach conflict resolution or mediation skills
Foster appropriate expression of emotions
Violence prevention
Parental involvement
Risk reduction

PROGRAM IMPLEMENTATION

FORMAT
Large group
Non-classroom based
Community-based

COMPONENTS
Access additional resources (e.g., funding, staff)
Focus groups to address future needs of the partnership

REFERRAL SOURCES
Self
Parent
Teacher
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
Outside Agency
Police Department

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
School identification card

GENERALIZATION PROCEDURES
Reduction of incidents of negative behavior in school and community

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Self-report
Community-based reports)

OUTCOMES THAT ARE EVALUATED
Specific problem behaviors (teen delinquency)
Social problem solving skills
Social skills
Reduction in risky behavior
Self-esteem
Generalization of program effects to other settings
Reduction in school discipline problems
Reduction in school violence

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program design/planning	60%
Program implementation	15%
Program evaluation	25%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Administrator
Community Mental Health Agency
Parents
Peers
Community Members

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION
Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction

Enhance Social Competency Program (ESCP)
University of Rochester Primary Mental Health Project & Rochester City School District

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PROGRAM DESCRIPTION

Enhance Social Competency Program (ESCP) is a preventive program implemented in pre-kindergarten and kindergarten classrooms for children who are at-risk for school adjustment and learning problems. ECSP includes 41 brief play activities. The goal of ECSP is to help young children learn basic social problem solving strategies. Specific ESCP objectives include: (a) developing self-control; (b) improving interpersonal sensitivity; (c) enhancing communication skills; (d) helping children to approach problems as part of everyday life; (e) helping them to learn to generalize their social problem solving skills; and (f) ultimately enhance their social competence, school readiness and chances for school success. A school psychologist has had the leading role in program design, coordinating and supervising program implementation, and program evaluation. Program efficacy research has revealed that ECSP is effective for enhancing on-task behavior, frustration tolerance, peer sociability, and assertiveness.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: (Multiple agencies)
Public schools, private schools
school health clinics, school-linked clinics
preschool programs

POPULATION

Age	4 - 5
Grade	Preschool, kindergarten
Gender	Both

Racial/ethnic composition (pilot program demographics)

African American	65%
Caucasian	20%
Hispanic	12%
Other	3%

FUNDING SOURCES

External grants (United Way)

PROGRAM GOALS

Enhance social competence
Increase self-esteem
Prevent placement in more restrictive setting
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Foster appropriate expression of emotions
Generalization of program effects

PROGRAM IMPLEMENTATION

FORMAT
Small group
Large group
Classroom-based
School-wide
District-wide

COMPONENTS
Staff training
Ongoing consultation with program staff

REFERRAL SOURCES
No referral needed

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
None needed

CRITERIA FOR TERMINATION
Complete specified program

GENERALIZATION PROCEDURES
Reinforcement in other settings
Training in multiple settings
Teacher training

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Rating scales
Standardized tests

OUTCOMES THAT ARE EVALUATED
Social problem solving skills
Social skills
Emotional well-being
Reduction in risky behavior
Self-esteem
Self-efficacy
Generalization of program effects to other settings
Enhanced school readiness and transition from pre-kindergarten and kindergarten
School adjustment

WRITTEN MATERIALS AVAILABLE

Description of program design
Program guide for implementation
Curriculum
Evaluation procedures
Evaluation results
Goals and objectives
Definition of population served

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program design/planning	40%
Program implementation	10%
Program evaluation	50%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist

Regular Education Teachers
Special Education Teachers
Community Mental Health Agency
Paraprofessionals

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I	Prevention

Primary Mental Health Project (PMHP)

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Deborah Johnson, School Psychologist, Director of Community Services
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PROGRAM DESCRIPTION

Primary Mental Health Project is a school-based prevention program designed to support young children's (pre-kindergarten through grade 3) adaptation to the school environment. Since its origin in 1957, PMHP's goals have been to reduce social, emotional and school adjustment problems and to improve learning skills and other school-related competencies. PMHP uses four key structural components: (a) focus on young children; (b) early screening and identification of school adjustment difficulties; (c) use of paraprofessional (child associates) to provide direct services to children; and (d) a role change for the school-based mental health professional, frequently the school psychologist. Child associates meet individually with children in a specially designated "play" room on the school campus, typically once a week for 12 to 15 sessions. The mental health professional is responsible for overall program management including screening and selection of children, and consistent, ongoing training and supervision of paraprofessionals. PMHP's main services are: (a) systematic early detection and screening in primary grades to identify children with problems; (b) establishing specific goals and objectives for working with identified youngsters; (c) providing immediate, intensive helping services for children "at-risk"; and (d) carefully evaluating program outcomes. The school psychologist may be the lead staff member in coordinating, implementing, and evaluating the program. Most critically, the school psychologist is responsible for training and supervision of paraprofessionals.

PMHP is validated through the New York State Education Department's "Sharing Successful Programs", and has become known nationally as an exemplary model for school mental health services. PMHP is currently implemented in over 1000 schools nationwide from New York to California. PMHP has been carefully researched since its inception and has been described as the most extensively researched school mental health project. Numerous outcome studies have been conducted by PMHP and by independent school districts within New York and nationwide. Collectively, these studies offer strong support for the program's effectiveness with sociodemographically diverse groups, in terms of improved school and behavioral adjustment. Moreover, program gains have been shown to have lasting value. Additionally, PMHP is a low-cost program with documented costs as low as 25% of private and 1% of inpatient clinical/psychiatric treatment.

NOTE: The following program information applies to PMHP as it is implemented nationally.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school, private school, community mental health agency, private non-profit agencies

POPULATION (Nationally)

# students/clients	30,000
Age	4-10
Grade	Kindergarten to grade 3

Racial/ethnic composition

African American	9%
Asian	4
Caucasian	50%
Hispanic	33%
Native American	1%

FUNDING SOURCES

External grants (specific funding streams in some states)
School funded
Funded with special education funds (occasionally)
Funded as non-special education support services
Funding from private agencies

PROGRAM GOALS

Enhance social competence
Increase self-esteem
Reduce referrals to special education
Increase participation in regular education
Prevent exacerbation of mild adjustment difficulties
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention (indirectly)
Dropout prevention (indirectly)
Improve academic functioning (indirectly)
Support school transitions
Parental involvement
Risk reduction
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual (primarily)
Small group
Non-classroom based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Self
Parent
Teacher
Multidisplinary Team (Program Team; Primary Referral Source)
Prereferral Intervention Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
Screening Process (Primary Referral Source)

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Multiple levels of screening
Standardized tests
(Typically, select children who will benefit most)

CRITERIA FOR TERMINATION
Meet outcome criteria
Deemed inappropriate for program
Typically 10 to 15% repeat a second program cycle

GENERALIZATION PROCEDURES
Reinforcement in other settings
Parent training
Booster or follow-up sessions (primary means)

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Self-report
Rating scales (completed by child, teacher, paraprofessional, professional)
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Target behaviors (shy-withdrawn, acting-out, learning behaviors)
Specific problem behaviors
Social problem solving skills
Academic functioning (in some studies)
Social skills
Emotional well-being
Reduction in risky behavior (shy-withdrawn, acting-out, learning behaviors)
Generalization of program effects to other settings
Maintenance of program effects
Move or transfer to less restrictive setting
Reduction in school discipline problems
Increase in attendance rates
Reduction in referrals to special education

Reduction in special education placements

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Program guide for implementation
Intervention techniques
Evaluation procedures
Evaluation results
Cost-benefit analysis
Staff training
Description of program model
Definition of population served
Eligibility criteria

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	20%
Program implementation	60%
Program evaluation	20%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Certified Counselor
Regular Education Teachers
School Nurse
School Administrator
School Board Member
Community Mental Health Agency
Paraprofessionals
Parents
Program recipients

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level II	Risk reduction
Level III	Early intervention

A Pro-social Classroom Program for the Scarsdale Elementary Schools Scarsdale School District

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PROGRAM DESCRIPTION

The Scarsdale Social Skills program is a sequential and structured classroom approach that teaches elementary students multiple ways to be aware of their own reactions, to be sensitive to different viewpoints, and to solve interpersonal problems. This cognitive/affective curriculum which was developed by Scarsdale faculty is developmentally appropriate and differentiated for each grade level. The instruction is done by classroom teachers with support from a district psychologist and includes modeling, discussion, literature-application, and role-playing that involves small group and whole class activities. By addressing deficits in social skills within a classroom setting, shy, inhibited children become more comfortable and those with excesses become less impulsive and more sensitive. Focus on an appreciation of self and of others, both individually and collectively, promotes life-skills that transcend school by teaching communication and coping skills. The school psychologist was involved with program design, implementation, and evaluation. The school psychologist worked in collaboration with the teacher to develop and differentiate curriculum by grade level. She also team teaches all social skill classes, leads small groups, and conducts evaluation.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school

POPULATION

# students/clients	1,500
Age	7-11
Grade	Elementary school
Gender	50% female, 50% male

Racial/ethnic composition

African American	1%
Asian	25%
Caucasian	70%
Other	4%

FUNDING SOURCES

School funded

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Improve academic functioning
Parental involvement
Risk reduction
Generalization of program effects

PROGRAM IMPLEMENTATION

FORMAT
Large group
Classroom-based
School-wide
District-wide

COMPONENTS
Staff training
Ongoing consultation with program staff
Teacher training
Implementation by multiple facilitators/educators
Booster or follow-up sessions

CRITERIA FOR TERMINATION
Complete specified program

GENERALIZATION PROCEDURES
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Parent training

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Self-report
Rating scales
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Knowledge
Target behaviors (positive social interactions)
Social problem solving skills
Social skills
Reduction in school discipline problems

WRITTEN MATERIALS AVAILABLE

Description of program design
Curriculum
Intervention techniques
Goals and objectives

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program design/planning	10%
Program implementation	80%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Regular Education Teachers
Special Education Teachers
Parents
Program Recipients
Peers

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on program efficacy
Research on risk and protective factors

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level III.	Early intervention

School Based Mental Health Initiative (SBMHI)
Martin Luther King School
Westchester Jewish Community Services-Kids in Community Schools Program (KICS)

Megan S. Flynn, Ph.D.
Program Director
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Yonkers, NY 10701
914-376-5125 (Phone)

PROGRAM DESCRIPTION

The Kids in Community Schools (KICS) Program is an on-site mental health program at the Martin Luther King School in Yonkers, NY, funded through the New York State Office of Mental Health and administered through Westchester Jewish Community Services. The goals of the program are: (a) to maintain emotionally disturbed or at-risk children in the least restrictive setting; (b) to develop preventative mental health services through collaboration with families, school and the community; and (c) to enhance community mental health services for children. The program provides on-site, direct mental health services including child and family treatment, crisis intervention, individual and family respite, and psychological, psychiatric, and psychoeducational services. In addition, the program provides social skills and bereavement groups, domestic violence services, in class interventions, individualized behavioral incentive programs, extended day enhancement, a mentoring program, local camp expansion for SED and at-risk children, and coordination of services with school, medical and community programs and mental health providers. The psychologist's role in the program includes design, implementation, administration, direct service, and evaluation. The program research component has demonstrated program effectiveness for (a) reducing school behavioral problems and adjustment disorders; (b) reducing suspensions; (c) increasing attendance; (d) improving academic performance; and (e) reducing day treatment placements and contacts with the county Mobile Crisis Team.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school, school-linked clinic, community mental health agency, Office of Mental Health - School Based Mental Initiative

POPULATION

# students/clients	70 (Direct clinical services) 150-200 (Indirect mental health services)
Age	5-12
Grade	Preschool, elementary school
Gender	40% female, 60% male

Racial/ethnic composition

African American	75%
Asian	1%
Caucasian	8%
Hispanic	23%
West Indies	1%
Other	1%

FUNDING SOURCES

External grants (NY State - Office of Mental Health)

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Increase self-efficacy

Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Generalization of program effects
Fostering school-home and community bonds
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group (family)
Large group
Classroom-based
Non-classroom based
School-wide
Community-based
Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)
Development of community-school-parent advisory committee

REFERRAL SOURCES
Self
Parent
Teacher
Multidisciplinary Team
Prereferral Intervention Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Medical Clinic
Outside Agency
School Administration

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Multiple levels of screening
Standardized tests
Interviews

CRITERIA FOR TERMINATION
Meet outcome criteria

ATTRITION RATE: 10% (family relocations and children transitioning from elementary to middle school)

GENERALIZATION PROCEDURES
Training in natural context
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Training in multiple settings
Parent training
Teacher training
Implementation by multiple facilitators/educators

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Rating scales
Standardized tests
Anecdotal records
Parent, teacher assessment
Intensive Day Treatment and Mobil Crisis team usage rates
Pre test- and post test report cards for academic performance
Attendance records/Suspension records

OUTCOMES THAT ARE EVALUATED
Target behaviors (Conners' Rating Scales)
Specific problem behaviors
Social problem solving skills
Academic functioning
Social skills
Emotional well-being
Reduction in risky behavior (suicidal, aggressive)
Self-esteem
Generalization of program effects to other settings
Maintenance of program effects
Reduction in school discipline problems
Reduction in school violence
Increase in attendance rates
Increase in inclusion/retention in regular education
Reduction in special education placements
Lower rate of hospitalization
Increased parent involvement

WRITTEN MATERIALS AVAILABLE

Description of program design
Evaluation procedures

Evaluation results
Intake and exit procedures
Goals and objectives
Definition of population served
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

PSYCHOLOGIST'S PROGRAM INVOLVEMENT *(Psychologist who directs the program is not a school psychologist) (How does the psychologist allocate his/her program time?)*

Program design/planning	30%
Program implementation	60%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Nurse and Medical Clinic Nurse-Practitioner
School Administrator
Paraprofessionals
Parents
Peers
Community members and community programs/agencies

THEORETICAL BASE

Multiple

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

OHIO (OH)

Positive Education Program (PEP) Early Intervention Center

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PROGRAM DESCRIPTION

At Positive Education Program Early Intervention Centers, (PEP) parents learn from other parents how to help their preschool children develop social interaction and cognitive problem solving skills. Program participants reflect Cleveland's widely diverse cultural heritage. Daytime, evening, and Saturday programs are offered. Relatively few professionals are needed to structure the service and provide needed support, making the model highly cost effective. As evidence of the program's effectiveness, the percentage of children identified as needing special education services decreased from 65% at program entry to 35% at program exit. The school psychologist is responsible for program coordination, conducting children's intake, report writing and data collection.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school, community mental health agency, United Way

POPULATION

# students/clients	200 families
Age	Birth to adult
Grade	Preschool
Gender	30% female 70% male

Racial/ethnic composition

African American	39%
Caucasian	50%
Hispanic	9%
Other	2%

FUNDING SOURCES
School funded
Funded with special education funds
Funded as non-special education support services
Medicaid
County Mental Health Board, United Way

PROGRAM GOALS
Enhance social competence
Teach specific social skills
Reduce referrals to special education
Increase participation in regular education
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Support school transitions
Parental involvement
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Classroom-based
Non-classroom based
Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Parent
Multidisciplinary team
Outside agency

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Standardized tests
Interviews
Ages and Stages Questionnaire

Parenting Stress Index

CRITERIA FOR TERMINATION
Complete specified program

ATTRITION RATE: 35%

GENERALIZATION PROCEDURES
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Parent training
Implementation by multiple facilitators/educators
Booster or follow-up sessions
Daily parent-child training sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Self-report
Rating scales
Anecdotal records
Multiple data collection techniques

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Target behaviors (cooperation, language development, group participation)
Move or transfer to less restrictive setting

WRITTEN MATERIALS AVAILABLE

Description of program design
Program guide for implementation
Intervention techniques
Evaluation procedures
Evaluation results
Staff training
Intake and exit procedures
Goals and objectives
Definition of population served
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program design/planning	5%
Program implementation	85%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Special Education Teachers
School Nurse
School Administrator
Paraprofessionals
Parents
Program Recipients

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on program efficacy
Research on population needs

PROGRAM EVALUATION
Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

OKLAHOMA (OK)

Attention-Deficit/Hyperactivity Disorder (ADHD) Support Group for Students and Attention-Deficit/Hyperactivity Disorder (ADHD) Support Group for Parents
Jenks Public Schools

Linda Sanders
School Psychologist
205 East B Street
Jenks, OK 74037
918-299-4411 (Phone)
918-299-9197 (Fax)
sandel@www.jenksusa.k12.ok.us

PROGRAM DESCRIPTION

The Attention Deficit Hyperactivity Disorder (ADHD) support group is designed to help students be more successful in school with minimum need for referral for formal testing, evaluation, and special education services. The purpose of the program is to equip students and parents with information, peer support, and problem-solving skills so that the student with ADHD can achieve greater academic success. A teacher handbook is distributed to provide information on DSM-IV characteristics of ADHD, teaching a child with ADHD, classroom accommodations, talking to parents, ADHD support groups, general ADHD medication information, and assessment procedures. A parent handbook provides information on living with a child with ADHD, home management suggestions, general medication information, assessment procedures, discipline techniques, and common questions/answers about ADHD. The school psychologist is involved with program design, implementation, and evaluation. She facilitates two support groups for ADHD, one for students and one for their parents.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school

POPULATION	
# students/clients	100 approx.
Age	14 to adult
Grade	High school
Gender	49% female, 51% male
Racial/ethnic composition	
African American	4%
Asian	2%
Caucasian	87%
Hispanic	2%
Native American	5%

FUNDING SOURCES

School funded
Funded as non-special education support services

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Improve academic functioning
Parental involvement

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Large group
Classroom-based
Non-classroom based

COMPONENTS
Ongoing consultation with program staff

REFERRAL SOURCES
Self
Parent
Teacher
Prereferral intervention team
Press releases

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Other (diagnosis by physician)

GENERALIZATION PROCEDURES
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Parent training
Teacher training
Implementation by multiple facilitators/educators

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Anecdotal records
Student and parent feedback

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Specific problem behaviors (inattention, impulsivity, and hyperactivity)
Social problem solving skills
Academic functioning
Social skills
Self-esteem
Self-efficacy
Generalization of program effects to other settings
Move or transfer to less restrictive setting
Reduction in school discipline problems
Increase in inclusion/retention in regular education
Reduction in referrals to special education
Reduction in special education placements

WRITTEN MATERIALS AVAILABLE

Intervention techniques
Staff training
Intake and exit procedures
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	10%
Program implementation	85%
Program evaluation	5%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
School Administrator
Parents
Program Recipients
Peers
Colleagues
Committee Members

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention

Drug Free Youth (DFY)
Jenks Public Schools

Linda Sanders
School Psychologist
205 East B Street
Jenks, OK 74037
918-299-4411 (Phone)
918-299-9197 (Fax)
sandel@www.jenksusa.k12.ok.us

PROGRAM DESCRIPTION

Drug Free Youth (DFY) is primarily a prevention program that rewards youth who choose an alcohol and drug free life and are willing to prove it through a voluntary, confidential drug test. DFY utilizes positive peer pressure and community incentives to encourage students to choose not to use alcohol or other drugs. It also provides the incentive and means for those who use, but are not yet chemically dependent, to stop. Strengths of DFY include the following:

1. DFY benefits the students, parents, and entire community, because it is primarily a prevention program.
2. DFY uses positive incentives to combat the use of drugs and alcohol.
3. DFY is totally voluntary, giving students a way to "prove" they are drug free.
4. DFY is completely confidential.
5. DFY creates positive peer pressure to discourage drug and alcohol use.
6. DFY demonstrates that the actual benefits of a "no use" commitment outweigh the perceived benefits of using.
7. DFY creates opportunities for the development of leadership skills of students.
8. DFY generates community support in providing alcohol/drug-free activities for youth. The school psychologist is the co-sponsor of this program.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
# students/clients	1,000 approx.
Age	4-19
Grade	Elementary school through high school
Gender	49% female, 51% male

FUNDING SOURCES

External grants (Drug-Free Schools)

PROGRAM GOALS

Increase self-esteem
Reduce specific behavioral problems
Increase social problem solving skills
Risk reduction
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Large group
Classroom-based
Non-classroom based
School-wide
District-wide
Community-based

COMPONENTS
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Self
Teacher
School discipline officer

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Attendance and participation

GENERALIZATION PROCEDURES
Teaching self-monitoring or verbal mediators
Reinforcement in other settings

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Anecdotal records
Surveys, student/staff feedback

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Social problem solving skills
Reduction in risky behavior
Self-esteem
Generalization of program effects to other settings

WRITTEN MATERIALS AVAILABLE

Description of program design
Program guide for implementation
Curriculum
Goals and objectives
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)
Program implementation 100%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Certified Counselor
School Nurse
School Administrator
Parents
Program Recipients
Peers
Community Members

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on program efficacy
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION
Program acceptability
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention

Parents as Teachers
Jenks Public Schools

Kricket Harden
Director
Jenks Public Schools
205 E. B. St.
Jenks, OK 74037
918-298-0357 (Phone)
918-299-9197 (Fax)

PROGRAM DESCRIPTION

Parents as Teachers is an early intervention program which recognizes parents as the child's first and most important teacher, and helps to empower parents in this role. The program supports families with appropriate developmental information and screening to ensure that all children are ready to learn more by the time they reach kindergarten. Services offered by the program include the following: monthly home visits, weekly Stay and Play programs, weekly preschool programs, monthly group meetings, monthly newsletter, clothing exchange, weekly teen parent group, biweekly newspaper articles, developmental screening, newborn packets, and a parent lending library (reading incentive program). For every one dollar spent on the program, the school district saves four to seven dollars on special education services. The school psychologist provides support for parent educators in evaluating specific parent or child concerns and referring parents for support or diagnostic services.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school

POPULATION

#students/clients	125 families
Age	Children 0-5 years and their parents
Grade	Preschool
Gender	
Children	50% female, 50% male
Parents	75% female, 25% male

Racial/ethnic composition

African American	1%
Asian	1%
Caucasian	96%
Native American	2%

FUNDING SOURCES

School funded
Linked to school-based health clinic (i.e., school nurse)
Funded as non-special education support services
Community fund-raising

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy

Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Large group
Classroom-based
Non-classroom based
District-wide
Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Self
Parent
Teacher
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
Outside Agency

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation for identifying pregnant teens attending school.
All parents living within the school district with children ages 0 to 5 years are eligible.

CRITERIA FOR TERMINATION
Complete specified program (exceed age limit)

GENERALIZATION PROCEDURES
Training in multiple settings
Parent training
Teacher training
Implementation by multiple facilitators/educators (state-and nation-wide)
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Self-report
Rating scales
Standardized tests
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Target behaviors (early childhood concerns)
Specific problem behaviors (early childhood concerns)
Social problem solving skills
Academic functioning (teen parents)
Social skills
Emotional well-being
Reduction in risky behavior (teen parents)
Self-esteem
Self-efficacy
Generalization of program effects to other settings
Maintenance of program effects
Reduction in school discipline problems
Reduction in school violence
Increase in attendance rates
Increase in graduation rates
Increase in inclusion/retention in regular education
Reduction in referrals to special education
Reduction in special education placements
Community outcomes
Savings in money spent by the district on special education services

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Program guide for implementation
Curriculum
Intervention techniques
Evaluation procedures
Evaluation results
Cost-benefit analysis
Staff training
Intake and exit procedures
Procedures for insuring generalization of program effects
Goals and objectives

Theoretical-empirical foundation
Description of program model
Definition of population served
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program evaluation 100%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Nurse
School Administrator
School Board Member
Community Mental Health Agency
Parents
Community Members

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs
Research on risk and protective factors
Independent studies to validate program effectiveness

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I	Prevention
Level II	Risk reduction
Level III	Early intervention

PENNSYLVANIA (PA)

Chester County Prosocial Behavior System
Chester County Immediate Unit

Jerry McMullen, Ph.D.
School Psychologist
535 James Hance Court
Exton, PA 19341
610-524-5038 (Phone)
610-524-5167 (Fax)

PROGRAM DESCRIPTION

The Prosocial Behavior System consists of three components that operate simultaneously: (a) analysis of school climate and behavioral expectations; (b) trouble shooting, problem solving, and maintenance to address specific areas of concern; and (c) promotion of student discipline and responsibility. This system, which is educative rather than punitive, challenges behaviors and effectively addresses general qualitative changes in student behavior (e.g., disrespect, impulsivity, and inattention). It has proven successful with regular and special education students at preschool through high school levels. Each school adapts the system to meet its needs. When school-level implementation is not possible, modifications can be made for individual classroom use. The school psychologist designed the model for the program and assists in implementation and evaluation. He also serves as a behavior management consultant and trainer for the program. A needs assessment revealed that over the past ten years school staff felt students had become less respectful, less responsible, more aggressive, displayed more negative attitudes, were more inattentive, and used more inappropriate language. The Prosocial Behavior System is designed to address these qualitative changes in student behavior. Schools using the system have reported substantial effects. Compared with preintervention levels, Stetson Middle School reduced suspensions by 49% and fights and physical assaults by 64% in the second year of program implementation. Beaver Creek Elementary School reduced disciplinary suspensions from 33 to 1 in the first year of implementation.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school, private school, school-linked clinic, preschool

POPULATION	
# students/clients	61,095
Age	3-21
Grade	Preschool through high school
Gender	52% female, 48% male

Racial/ethnic composition (The schools differ dramatically in terms of ethnicity. The numbers listed represent the average percentage across the schools.)

African American	9%
Asian	2%
Caucasian	86%
Hispanic	3%
Other	<1%

FUNDING SOURCES

Little cost is involved

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Large group
Classroom-based
Non-classroom based
School-wide
Community-based
Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Parent training

REFERRAL SOURCES
Proactive-preventative program with intervention techniques built in

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
School-wide levels of suspension, discipline referrals, or physical assaults

CRITERIA FOR TERMINATION
On-going behavior management system

GENERALIZATION PROCEDURES
Training in natural context
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Training in multiple settings
Parent training
Teacher training
Implementation by multiple facilitators/educators
Booster or follow-up sessions
Training community mental health workers

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Archival records re: suspension, discipline referrals, etc.)

OUTCOMES THAT ARE EVALUATED
Specific problem behaviors (varies with setting)
Social skills
Reduction in risky behavior (e.g., bus misbehavior)
Maintenance of program effects
Reduction in school discipline problems
Reduction in school violence

WRITTEN MATERIALS AVAILABLE

Program guide for implementation
Intervention techniques
Evaluation results
Staff training
Procedures for insuring generalization of program effects
Goals and objectives
Theoretical-empirical foundation
Description of program model

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	30%
Program implementation	60%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Nurse
School Administrator
Community Mental Health Agency
Paraprofessionals
Peers

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs

PROGRAM EVALUATION

Program acceptability

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction

Level III.	Early intervention
Level IV.	Treatment

Child and Adolescent Service System Program (CASSP)
Seneca Highlands Intermediate Unit of Education- #9

Daniel Kysor
School Psychologist
306 North Main St., P. O. 149
Coudersport, PA 16915
814-274-8414 (Phone)
814-274-7620 (Fax)

PROGRAM DESCRIPTION

The Child and Adolescent Service System Program (CASSP) is a multi-system, team approach of coordination and decision-making for children and adolescents who have specific mental health needs. The CASSP process provides an opportunity for the key agencies, individuals, and family members who are providing services to emotionally disturbed and other mental health diagnosed children to meet and jointly develop a plan which addresses the needs of the child and his/her family. Regular members of the CASSP team include representatives of the following child serving systems: Juvenile Probation, Special Education, Mental Health/Mental Retardation and Drug and Alcohol, Wrap Around Service Providers, the child's parents and school. The CASSP philosophy promotes a child-centered and community-based approach. The four major values are: (a) child-centered and family focused; (b) parents as partners; (c) multi-system decision-making; and (d) cultural competence. A variety of mental health services are available through CASSP. These include, but are not limited to family-based mental health services, wrap-around services, family support services, school-based mental health services, community-based residential facilities, case management, early intervention programs and student assistance programs. The role of the school psychologist is to offer information from completed evaluations. The school psychologist also serves as a resource for educational issues. The program successfully closed 9% of the cases for the 95-96 year. Thirteen percent of the population was referred for residential placement. 78% cases are still open with children still residing in the home.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school, school-linked clinic, community mental health agency, interagency approach

POPULATION

# students/clients	74 students 95-96, 45 students 96-97
Age	3-18
Grade	Preschool through high school
Gender	40% female, 60% male
Racial/ethnic composition	
Caucasian	99%
Other	1%

FUNDING SOURCES

Medicaid

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Increase social problem solving skills.
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Improve academic functioning
Parental involvement
Risk reduction
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Classroom-based
Non-classroom based
Community-based
Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Parent
Teacher
Multidisciplinary Team
Prereferral Intervention Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
Outside Agency

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Multiple levels of screening
Standardized tests
Interviews
Curriculum-based measures
DSM-IV diagnosis

CRITERIA FOR TERMINATION
Meet outcome criteria
Deemed inappropriate for program

ATTRITION RATE: 13%

GENERALIZATION PROCEDURES
Reinforcement in other settings
Parent training
Implementation by multiple facilitators/educators
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Target behaviors (individualized)
Social problem solving skills
Academic functioning
Social skills
Reduction in risky behavior (able to be maintained in the community)
Generalization of program effects to other settings
Maintenance of program effects
Reduction in school discipline problems
Lower rate of hospitalization
Community outcomes (community law abiding, socially appropriate, etc.)

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Intake and exit procedures
Goals and objectives
Description of program model
Definition of population served
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)
Program implementation 100%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Certified Counselor
School Administrator
Parents
Program recipients

THEORETICAL BASE

Single (Ecological)

PROGRAM EVALUATION

Program acceptability
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level III.	Early intervention
Level IV.	Treatment

RESOLVE Parents Adolescents Community Treatment School (PACTS) Colonial Northampton Intermediate Unit 20

George M. Makovec
Program Supervisor
6 Danforth Drive
Easton, PA 18045-7899
610-252-5550 (Phone)
610-252-5740 (Fax)

PROGRAM DESCRIPTION

A service-provider continuum for children who display abnormal psychiatric behavioral characteristics on a regular basis has been created using a family-focused model, Parents Adolescents Community Treatment School (PACTS). This model allows children to stay within the mainstream of the public school system by wrapping around direct services for all involved parties. In addition, financial obligations are redirected for both Department of Education and the Department of Human Resources. The RESOLVE Service Model has as its core approach the solution-oriented therapeutic philosophy to treatment. In essence, this philosophy recognizes the life-enhancing (solutions) aspects of people's lives rather than focusing mainly on the pathological (problem) aspects. It is this program's contention that solutions to identified problems rest within the individual and his/her social network, and that the role of the therapist is to facilitate the empowerment of the client to become a positive self-change agent. The district school psychologist provides input to interagency teams for treatment and educational program development.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: service agency	School-based public
POPULATION	
# students/clients	169
Age	7-21
Grade	Elementary through high school
Gender	24% female, 76% male

Racial/ethnic composition

African American	11%
Caucasian	71%
Hispanic	12%
West Indies	6%

FUNDING SOURCES

External grants (Pennsylvania Department of Education)
School funded
Linked to school-based health clinic
Funded with special education funds
Funded as non-special education support services
Funding from private agencies
Medicaid
Private insurance

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Classroom-based
Non-classroom based
Community-based
Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Self
Parent
Teacher
Multidisciplinary Team
Prereferral Intervention Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
School Discipline Officer
Outside Agency
Private Providers

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Multiple levels of screening
Interviews
Medical need, interagency meeting

CRITERIA FOR TERMINATION
Meet outcome criteria
Deemed inappropriate for program
Interagency meeting and case review

GENERALIZATION PROCEDURES
Training in natural context
Teaching self-monitoring or verbal mediators
Training in multiple settings
Parent training
Teacher training
Implementation by multiple facilitators/educators
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Rating scales
Anecdotal records
Individualized education plans, program quality indication checklist

OUTCOMES THAT ARE EVALUATED
Target behaviors (non-compliant)
Specific problem behaviors (DSM-IV diagnosed)
Social problem solving skills
Academic functioning
Social skills
Emotional well-being
Reduction in risky behavior (all)
Self-esteem
Self-efficacy
Maintenance of program effects
Move or transfer to less restrictive setting
Reduction in school violence
Increase in attendance rates
Increase in graduation rates
Increase in inclusion/retention in regular education
Reduction in referrals to special education
Lower rate of hospitalization
Community outcomes

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Program guide for implementation
Intervention techniques
Evaluation procedures
Evaluation results
Staff training
Intake and exit procedures
Goals and objectives
Theoretical-empirical foundation
Description of program model
Definition of population served
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	15%
Program implementation	75%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Certified Social Worker
Certified Counselor

Regular Education Teachers
Special Education Teachers
School Nurse
School Administrator
School Board Member
Community Mental Health Agency
Paraprofessionals
Parents
Program Recipients
Community Members

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Staff experience

PROGRAM EVALUATION
Program acceptability
Program integrity

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

RHODE ISLAND (RI)

Parent/Teacher Education Program
Coventry Public Schools

Louis Turchetta, Ed.D.
School Psychologist
15 Foster Drive
Coventry, RI 02816
401-822-9466 (Phone)
401-822-9456 (Fax)

PROGRAM DESCRIPTION

The parent education program is conducted in the evenings, once a week for nine weeks. This nine-week cycle is repeated three times during the school year. The school system's vocational "child care" program provides child care services while the parents attend the classes. The groups are run by pairs of mental health professionals, who are social workers, school psychologists, and/or guidance counselors. The program currently offers four groups: (a) parents of teenagers; (b) parents of elementary age students; (c) parents of children birth to 5 years; and (d) deaf parents. An after-school teacher education program is conducted every other week for one hour throughout the school year. The program offers continuing education credits to its participants. The five school psychologists in the district have designed and implemented both the parent and teacher programs.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
# students/clients	>600 parents 12 teachers
Grade	Preschool through high school
Gender	50% female, 50% male
Racial/ethnic composition	
African American	2%
Asian	1%
Caucasian	97%

FUNDING SOURCES

External funded (State Department of Education)
School funded
Funded with special education funds
Funded as non-special education support services
Funding from private agency (COZY)

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Violence prevention
Improve academic functioning
Parental involvement
Generalization of program effects

PROGRAM IMPLEMENTATION

FORMAT
District-wide

COMPONENTS
Staff training
Ongoing consultation with program staff

REFERRAL SOURCES
Self
Parent
Teacher
Multidisciplinary Team
Prereferral Intervention Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
School Discipline Officer
Outside Agency
Archival Records

CRITERIA FOR TERMINATION
Complete specified program

ATTRITION RATE: 20%

GENERALIZATION PROCEDURES
Parent training
Teacher training
Implementation by multiple facilitators/educators
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Self-report
Rating scales

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Social problem solving skills
Reduction in risky behavior
Self-esteem
Self-efficacy
Generalization of program effects to other settings

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Program guide for implementation
Curriculum
Evaluation procedures
Evaluation results
Staff training
Goals and objectives

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program design/planning	15%
Program implementation	80%
Program evaluation	5%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Certified Social Worker
Certified Counselor
School Administrator
Paraprofessionals

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on program efficacy

PROGRAM EVALUATION
Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

SOUTH CAROLINA (SC)

New Endeavors Day Treatment Program
Charleston County School District (CCSD)

Debra E. Hanna
Coordinator, Student Services
75 Calhoun Street
Charleston, SC 29401
803-937-6540 (Phone)
803-937-6535 (Fax)

PROGRAM DESCRIPTION

New Endeavors Day Treatment Program is a cooperative effort between the Charleston County School District, Charleston/Dorchester Community Mental Health Center, Continuum of Care, and Carolina Youth Development. The primary focus of the program is to provide comprehensive educational and therapeutic services to students and families. All students are assigned to a mental health counselor who works with the child and the entire family unit. Services provided by the counselor include individual, family, and group therapy. In addition, the counselor also works to help the family unit in dealing with problems that affect the entire family. An educational staff is responsible for carrying out the child's Individual Education Plan. The curriculum includes: Reading, Math, Vocational Education, Social Skills Training, and Independent Living Skills. Recreational therapy is scheduled daily to provide the student with an opportunity to improve and practice both physical and social skills. Students who reach level three are eligible for a work experience in the community to provide information concerning the behavioral and employment skills required of real jobs. New Endeavors staff help students and their families to contact other community agencies that can provide needed services (such as adequate housing, transportation, etc.). The school psychologist is involved primarily in program implementation. The school psychologist conducts psychological evaluations, re-evaluations, consultations, and pre-expulsion meetings. Data from the program evaluation include: (a) 8 students graduated with certificates of attendance from Charleston County Schools; (b) 2 students were placed in full-time jobs in the public; (c) 2 students were mainstreamed into less restrictive placements in a regular high school; (d) 6 students were transferred to adult mental health programs; and (e) one student was placed in-patient for substance abuse treatment.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school (separate school from traditional school)

POPULATION

# of students/clients	47
Age	6-19
Grade	Elementary through high school
Gender	13% female, 87% male
Racial/ethnic composition	
African American	66%
Caucasian	34%

FUNDING SOURCES

External grants (Mental health, United Way)
School funded
School mandated
Funded with special education funds
Medicaid

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Parental involvement
Risk reduction
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Classroom-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access traditional resources (e.g., funding, staff)

REFERRAL SOURCES
Multidisciplinary team referral
Mental health agency

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Multidisciplinary team referral
Referral packet

CRITERIA FOR TERMINATION
Meet outcome criteria
Complete specified program
Deemed inappropriate for program

ATTRITION RATE: 2%

GENERALIZATION PROCEDURES
Training in natural context
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Training in multiple settings
Parent training
Teacher training
Implementation by multiple facilitators/educators
Booster or follow-up sessions
Follow-up provided by transition teacher

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Rating Scales
Standardized tests
Anecdotal records
School to work transition

OUTCOMES THAT ARE EVALUATED
Knowledge
Target behaviors (aggression)
Social problem solving skills
Academic functioning
Social skills
Emotional well-being
Reduction in risky behavior
Self-esteem
Self-efficacy
Generalization of program effects to other settings
Maintenance of program effects
Move or transfer to less restrictive setting
Reduction in school discipline problems
Reduction in school violence
Increase in attendance rates
Lower rate of hospitalization
Community outcomes

WRITTEN MATERIALS AVAILABLE

Description of program design
Program guide for implementation
Intake and exit procedures
Procedures for insuring generalization of program effects
Goals and objectives
Definition of population served
Eligibility criteria

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT *(How does the school psychologist allocate his/her time?)*

Program implementation	20%
Program evaluation	80%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Certified Social Worker
Certified Counselor
Special Education Teachers
School Nurse
School Administrator
Community Mental Health Agency
Paraprofessionals
Parents
Program Recipients
Community Members

THEORETICAL BASE
Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs
Research on risk and protective factors
Historical success and data (over 30 years) of the program

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level IV. Treatment

SOUTH DAKOTA (SD)

In School Collaboration Between Home and School with Children's Specialty Clinic and School Psychology
Lennox School District No. 41-4

Tina M. Wranek, Ed.S.
Certified School Psychologist
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Lennox, SD 57039-0038
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605-647-2201 (Fax)

PROGRAM DESCRIPTION

The Lennox School District and the Children's Specialty Clinics worked together for four years with parents to provide services to children with disabilities. As part of this cooperative effort, the school district serves as a training site for child psychiatry interns. The interns' responsibilities include client-centered consultation, observation and direct contact with students with attention or other behavioral difficulties, arranging parent and teacher meetings, and recommending services. The school psychologist and the Student Services Director coordinate and supervise all the activities in which the child psychiatry fellows are engaged. These activities include parent meetings, assessment, and follow-up. Informal evaluations have been conducted by the school throughout the program's four year history. The program has given parents and children better, quicker, and more cost-effective access to the medical community. Parents have been grateful for this assistance.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
# students/clients	200
Age	Birth-21
Grade	Preschool through high school
Gender	50% female, 50% male
Racial/ethnic composition	
Caucasian	100%

FUNDING SOURCES

School funded
Funded with special education funds
Medicaid
Private insurance

PROGRAM GOALS

Reduce referrals to special education
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Risk reduction
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group

COMPONENTS
Ongoing consultation with program staff
Obtain written consent

REFERRAL SOURCES
Teacher
Mental Health Support Staff (Psychologist)
Director of Student Services

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Multiple levels of screening
Standardized tests
Interviews

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Reduction in risky behavior
Reduction in school discipline problems
Reduction in school violence

Increase in inclusion/retention in regular education
Reduction in referrals to special education

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	25%
Program implementation	50%
Program evaluation	25%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
School Administrator

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level II.	Risk reduction
Level III.	Early intervention

Social Skills Inclusion Model
Rapid City Area Schools

Judy Kennedy
School Psychologist
Rapid City Schools
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Rapid City, SD 57702
605-394-4036 (Phone)
605-394-5119 (Fax)

PROGRAM DESCRIPTION

The Social Skills Inclusion Model is a preventive program designed to meet the needs of children who enter school with insufficient social skills to become successful. The program also is beneficial for typically developing children as it teaches and reinforces the skills that are necessary in order to be successful in relationships and in school. The Social Skills Inclusion Model is designed to be implemented in the regular classroom. It contains 78 different social skills lessons in 7 areas. The 7 areas include: (a) Classroom Skills; (b) Friendship Skills; (c) Expressing Feelings; (d) Relieving Stress; (e) Solving Problems; (f) Replacement Skills for Aggression; and (g) Self-Esteem. Two school psychologists designed the curriculum to ensure that best practices for social skills training were included, and that the lessons could be easily implemented by the teacher in the regular classroom. "Think aloud" scripts (specific scripts for commonality of language), establishment of need, modeling, role playing, and opportunities for transfer of the skill are provided. The school psychologist designed the curriculum, trained staff to implement the program, and conducted follow-up evaluations. Program efficacy research has revealed that the Social Skills Inclusion Model is effective in preventing inappropriate behavior by teaching each child the behaviors needed for success in school, in dealing with one's feelings, in setting goals, and in having relationships. The elementary school, which was the site of a school-wide field study, experienced a 75% decrease in detentions over a 4-year period.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school

POPULATION

# students/clients	8,000
Age	5-12
Grade	Elementary school
Gender	48% female, 52% male

Racial/ethnic composition

African American	5%
Asian	2%
Caucasian	60%
Hispanic	2%
Native American	30%

Other 1%

FUNDING SOURCES

External grants (US West/Hasbro)

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Large group
Classroom-based
School-wide
Community-based
Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Self
Teacher

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Pretest

CRITERIA FOR TERMINATION
Meet outcome criteria
Complete specified program

ATTRITION RATE: 0% (Taught to all students-grades kindergarten through fifth grade)

GENERALIZATION PROCEDURES
Training in natural context
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Training in multiple settings
Parent training
Teacher training
Implementation by multiple facilitators/educators
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Rating scales
Survey

OUTCOMES THAT ARE EVALUATED
Target behaviors (social skills)
Specific problem behaviors (social skills)
Social problem solving skills
Social skills
Emotional well-being
Reduction in risky behavior (aggression)
Self-esteem
Self-efficacy
Generalization of program effects to other settings
Maintenance of program effects
Reduction in school discipline problems
Reduction in school violence
Increase in attendance rates
Increase in inclusion/retention in regular education
Reduction in referrals to special education
Community outcomes (drop out rate, violence)

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Program guide for implementation
Curriculum
Evaluation procedures

Staff training
Procedures for insuring generalization of program effects
Description of program model
Definition of population served

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	40%
Program implementation	30%
Program evaluation	30%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Nurse
School Administrator
Paraprofessionals
Parents
Program Recipients
Peers

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention

TENNESSEE (TN)

Community Health Outreach (CHO)
Cherokee Health Systems

William Allen, Ph.D., NCSP
School Psychologist
Cherokee Health Systems
6350 West Andrew Johnson Hwy.
Talbot, TN 37877
423-581-3673 (Phone)
423-586-6041 (Fax)

PROGRAM DESCRIPTION

The Community Health Outreach (CHO) program is funded by the Department of Health and Human Services and is intended to integrate physical health care, mental health care, and the community. The program includes a physician, a nurse, a clinical psychology consultant, a school psychologist (.6FTE), and a number of paraprofessionals. The school psychologist assisted in program development, conducted school wide screenings of children at-risk for depression and anxiety, developed a program focused on problem solving skills, analyzed program data, and implemented rational-emotive education classes. Other CHO staff members conducted a wide variety of training programs in health and mental health areas. Training targets parents, teachers, students, health providers, and other community members. The program is ending its third year and soon will complete an evaluation of effectiveness in meeting program goals.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public School, school-linked clinic, community mental health agency

POPULATION

# students/clients	11, 410
Age	birth to death
Grade	preschool to adult high school
Gender	45% female, 55% male
Racial/ethnic composition	
African American	3%
Asian	<1%
Caucasian	96%
Hispanic	<1%

FUNDING SOURCES

External grants (Department of Health and Human Services)

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Crisis intervention
Violence prevention
Risk reduction
Integrate mental health and physical health care

PROGRAM IMPLEMENTATION

FORMAT
Small group
Large group
Classroom-based
Non-classroom based
School-wide
District-wide
Community-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Self
Parent
Teacher
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
Outside Agencies

GENERALIZATION PROCEDURES
Training in natural context
Parent training
Teacher training

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Interview
Rating scales

OUTCOMES THAT ARE EVALUATED
Attitudes/beliefs
Target behaviors (preventive self-care)
Generalization of program effects to other settings
Lower rate of hospitalization
Community outcomes
Increase in users of sponsoring agency

WRITTEN MATERIALS AVAILABLE

Curriculum
Intervention techniques
Evaluation procedures
Goals and objectives
Description of program model
Definition of population served
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	10%
Program implementation	80%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Nurse
School Administrator
Community Mental Health Agency
Parents
Program Recipients
Peers
Community Members

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs
Research on risk and protective factors
Documentation of the Primary Mental Health Project

PROGRAM EVALUATION

Program acceptability
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I	Prevention
Level III	Early intervention

Project BASIC
Cherokee Health Systems

Jama McDonald
William Allen
School Psychologist
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JamaMcD@AOL.COM

PROGRAM DESCRIPTION

Project BASIC is a prevention/mental health program implemented with all students in grades K through 3 in targeted schools. The goals are to enhance children's acquisition of skills related to mental health, to link community mental health services, and to build a supportive school setting. The program varies widely in each school but often includes large group lessons, small group counseling, individual counseling, home-based services, and school-wide climate enhancement efforts. School psychologists are heavily involved in implementing the program and have a small amount of time designated to evaluating the program. A recent program evaluation showed that teacher and parent ratings were significantly different between schools serviced by Project BASIC and matched schools. Children who participated in the Project BASIC were rated as having better coping skills, decreased shy/anxious behavior, increased frustration tolerance, improved assertiveness, and improved peer relations.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school, community mental health agency, special service to school

POPULATION

# students/clients	1,000
Age	5-14
Grade	Preschool through junior high school
Gender	50% female, 50% male
Racial/ethnic composition	
African American	5%
Caucasian	90%
Hispanic	5%

FUNDING SOURCES

External grants (MHMR of TN)
Funding from private agencies

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT

Individual
Small group
Large group
Classroom-based
Non-classroom based
School-wide
Home-based

COMPONENTS

Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)
Coordination through the state

REFERRAL SOURCES

Self
Parent
Teacher
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
Outside Agency
School Staff

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES

Observation
Interview
Self-report
Rating scales
Anecdotal records

OUTCOMES THAT ARE EVALUATED

Knowledge
Attitudes/beliefs
Reduction in risky behavior
Generalization of program effects to other settings
Maintenance of program effects
Reduction in school discipline problems
Community outcomes

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Program guide for implementation
Curriculum
Goals and objectives

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	20%
Program implementation	70%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Regular Education Teachers
Special Education Teachers
School Administrator
Community Mental Health Agency
Paraprofessionals
Parents
Program Recipients

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I	Prevention
Level II	Risk reduction
Level III	Early intervention
Level IV	Treatment

TEXAS (TX)

Cypress-Fairbanks Independent School District
Department of Psychological Services
Reality Oriented Physical Experiences (ROPES) Program

Scott Poland, Ed.D.
Director of Psychological Services
P. O. Box 692003
Reo Annex
Houston, TX 77269-20003
713-460-7825 (Phone)
713-460-7843 (Fax)

PROGRAM DESCRIPTION

The Reality Oriented Physical Experiences Program (ROPES) has been in operation for six years. Operated by the school district's Department of Psychological Services, ROPES targets academically and behaviorally at-risk 4th through 12th grade students. Other students and staff also participate in the program. Over 8,000 individuals participated in the past year. The program consists of low and high elements. The low element provides participants the opportunity to communicate and problem solve as a group to overcome an obstacle. The high element uses basic mountain climbing equipment to provide participants the opportunity to enhance self-esteem and trust. After each element, ROPES facilitators discuss with participants what has been learned and how it can be applied to school and life goals. The ROPES program has greatly broadened the role of psychology in the schools. The school psychologists are involved in program design, implementation, and evaluation. Specifically, the school psychologists generated the interest for the ROPES program, raised the funding, implemented the program, and attended all activities.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
# students/clients	27,000
Age	9-20
Grade	4th-12th
Gender	50% female, 50% male

Racial/ethnic composition

African American	14%
Asian	5%
Caucasian	68%
Hispanic	18%
Native American	1%
Other	4%

FUNDING SOURCES

Donations and fund-raisers

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Small group
Large group
Non-classroom based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES

Self
Parent
Teacher
Multidisciplinary Team
Prereferral Intervention Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
School Discipline Officer

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY

Direct observation
Interviews
Teacher, staff, and student evaluations

GENERALIZATION PROCEDURES

Reinforcement in other settings
Teacher training
Implementation by multiple facilitators/educators
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES

Observation
Interview
Anecdotal records
Other (participant and staff evaluations)

OUTCOMES THAT ARE EVALUATED

Attitudes/beliefs
Target behaviors
Social problem solving skills
Social skills
Emotional well-being
Reduction in risky behavior
Self-esteem
Self-efficacy
Generalization of program effects to other settings
Reduction in school discipline problems
Increase in graduation rates

WRITTEN MATERIALS AVAILABLE

Program guide for implementation
Staff training
Intake and exit procedures
Goals and objectives
Description of program model
Definition of population served
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	20%
Program implementation	70%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Administrator

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

School-based Depression Prevention/Intervention Project
Houston Independent School District

Robbie N. Sharp
Psychologist
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713-961-0797 (Fax)
SHARP@BCM.TMC.EDU

PROGRAM DESCRIPTION

The School-based Depression Prevention/Intervention Project is a psychoeducational group approach teaching fifth graders identified at-risk for depression to monitor and modify their depressive behaviors. The program includes 10 group sessions based on stories and cartoon formats. The goal is to encourage children to identify self-defeating behaviors, to understand the relationship between mood and behaviors, and to modify these behaviors. Session objectives include teaching a rationale for the connection between behavior and mood, monitoring behavior for pleasant events and activity scheduling, monitoring for positive personal qualities and training for self-reinforcement, problem-solving, and attribution of cause for outcomes. This program is based on Stark's school-based model program and Rehm's self-monitoring model. The program was jointly planned and supervised by a school psychologist who was internship coordinator in a large city school district and a faculty member from a clinical psychology training program and their interns. Implementation and evaluation were carried out as a training project as well as an intervention for children, so weekly supervision was provided.

In the evaluation of pre-post test data, the most improvement was seen in the children who scored highest in the Children's Depression Inventory (CDI) and thus met the criteria for depression. Their improvement in depression symptoms was statistically significant. For students with elevated CDI scores, but not meeting criteria, improvement was noted, but not significant. No pre-test to post-test differences were seen in the Matson Evaluation or Social Skills for Youngsters Achenbach's Child Behavior Checklist. Anecdotal information from teachers and parents was quite favorable.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
# students/clients	150
Age	10-12
Grade	Elementary school
Gender	50% female, 50% male
Racial/ethnic composition	
African American	35%
Asian	2%
Caucasian	11%
Hispanic	52%
Native American	<1%

FUNDING SOURCES

School funded
University colleague provides computer and student group leader time

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase participation in regular education
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Increase self-efficacy
Foster appropriate expression of emotions
Support school transitions
Parental involvement
Risk reduction
Generalization of program effects

PROGRAM IMPLEMENTATION

FORMAT
Small group
Classroom-based
School-wide

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent

REFERRAL SOURCES
Parent
Teacher
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Behavioral checklists

CRITERIA FOR TERMINATION
Complete specified program

ATTRITION RATE: 1.5%

GENERALIZATION PROCEDURES
Parent training
Teacher training

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Interview
Self-report
Rating scales

OUTCOMES THAT ARE EVALUATED
Attitudes/beliefs
Social skills
Emotional well-being
Self-efficacy

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Program guide for implementation
Curriculum
Evaluation procedures
Evaluation results
Staff training
Procedures for insuring generalization of program effects
Goals and objectives
Description of program model
Definition of population served
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST 'S PROGRAM INVOLVEMENT

Program design/planning	5%
Program implementation	80%
Program evaluation	15%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
School Administrator
Parents
Program recipients

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on program efficacy
Research on risk and protective factors

PROGRAM EVALUATION
Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

Klein Leadership and Social Skills Program (KLASS)
Klein Independent School District
Special Education Department

Phil Chapman, M.Ed., NCSP
Coordinating School Psychology Services
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713-320-0995 ext. 304 (Phone)
713-379-6261 (Fax)

PROGRAM DESCRIPTION

The Klein Leadership and Social Skills Program (KLASS) is based on the premise that social skills play an integral part in helping children succeed in school and in the community. Program goals include development of social skills and empowerment through self-control. Program foci include: (a) providing students with choices and child-centered rationales; (b) teaching students alternatives to inappropriate behaviors; (c) providing students with practice in appropriate responding; and (d) parent training. The school psychologist was involved in program design, implementation and evaluation. He assisted in designing the training for the staff, teachers, and parents. The school psychologist and his colleagues also provided staff training and direct services for students and parents. Efficacy information has been gathered and utilized as data for a doctoral dissertation. Data indicate that the program has resulted in decreased student office referrals, increased time on-task, and improved academic achievement. In-depth analysis of the efficacy is available upon request.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
#students/clients	11,505
Age	3-14
Grade	Preschool, through junior high school
Gender	49% female, 51% male
Racial/ethnic composition	
African American	12%
Asian	7%
Caucasian	65%
Hispanic	15%

FUNDING SOURCES
External grants (Texas Education Agency Inclusion grant)
School funded
Funded with special education funds
Funded as non-special education support services

PROGRAM GOALS
Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Increase social problem solving skills
Teach conflict resolution or mediation skills
Foster appropriate expression of emotions
Crisis intervention
Improve academic functioning
Support school transitions
Parental involvement

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Large group
Classroom-based
Non-classroom based
School-wide
Community-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Access additional resources (e.g., funding, staff)
Parent training

REFERRAL SOURCES
Parent
Teacher
Multidisciplinary Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
Administrators

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Standardized tests
Request forms from parent or school staff

GENERALIZATION PROCEDURES
Training in natural context
Reinforcement in other settings
Training in multiple settings
Parent training
Teacher training
Implementation by multiple facilitators/educators
Booster or follow-up sessions
On-going consultation

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Self-report
Rating scales
Standardized tests
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Specific problem behaviors
Academic functioning
Social skills
Reduction in school discipline problems
Reduction in school violence
Increase in attendance rates
Increase in inclusion and retention in regular regular education
Community outcomes (parent involvement)

WRITTEN MATERIALS AVAILABLE

Program guide for implementation
Curriculum
Intervention techniques
Theoretical-empirical foundation
Description of program model

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	30%
Program implementation	60%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Nurse
School Administrator
Community Mental Health Agency
Paraprofessionals
Parents
Program Recipients

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I. Prevention

One School-One Psychologist: A Service Delivery Alternative
Reilly Elementary, Dallas Public Schools

Cindy Lifson, Ph.D.
School Psychologist
11230 Lippitt
Dallas, TX 75218
214-319-0130 (Phone)
214-319-0137 (Fax)

PROGRAM DESCRIPTION

The purpose of this program is to provide continuous mental health services to an at-risk population with the goal of improving their school performance. Implicit in this purpose is the provision of alternative ways for dealing with children who have behavior problems. The school psychologist is involved with program design, implementation, and evaluation.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
# students/clients	860
Age	5-12
Grade	Elementary
Gender	50% female, 50% male
Racial/ethnic composition	
African American	25%

Caucasian	45%
Hispanic	30%

FUNDING SOURCES

Linked to school-based health clinic
Assistant principal position was eliminated and the funds were used to hire a full time psychologist.

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Improve academic functioning
Parental involvement
Risk reduction
Generalization of program effects
Individualized goals

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	20%
Program implementation	75%
Program evaluation	5%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
School Administrator
Parents
Community Members

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on population needs

LEVELS OF SERVICE PROVISION

Level I	Prevention
Level II	Risk Reduction
Level III	Early intervention
Level IV	Treatment

UTAH (UT)

Project Success-Families, Agencies, Communities Together (FACT) Program
Heartland Elementary School

Lea Weaver
Program Coordinator
Project Success: Healthy Families Utah
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West Jordan, UT 84084
801-565-7533 (Phone)

PROGRAM DESCRIPTION

Project Success is one of the Families, Agencies, Communities Together (FACT) projects designed to facilitate change in how services are delivered to children. The shared value principles of family-centered, culturally competent, and community-based interventions are interwoven into the plan. Partnerships have been formed between families, the school, the health department, Valley Mental Health, Division of Child, Family Services, Office of Family Support, and Family Support Center to provide school-based services that encompass a wide range of prevention and treatment activities. Priority is placed on factors which place students and families "at-risk." Parallel systems of primary prevention and enhancement of resources are meshed to operate simultaneously to facilitate long term changes. The Case Management Team, which consists of the above listed participants, meets bi-weekly. The Coordinating Council, which consists of supervisors from each of the participating agencies, meets monthly to assure further collaboration. Each team serves 30-50 target children. Team activities include assessing the family's strengths and needs, advocating the success of the child and family by providing role modeling, intensive weekly to monthly home visits, developing service plans with the family, and providing integrated services to meet basic needs and propel the family toward greater functionality. These on-site teams provide ongoing assistance to educators. The school psychologist administers the program in the school.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school, community mental health agency, collaborative grant with five agencies: Family Support Center, Department of Children and Family Services, Office of Family Support, Health Department, Valley Mental Health

POPULATION

# students/clients	120 target children plus families
Age	5-9
Grade	Kindergarten through third grade
Gender	100% male
Racial/ethnic composition	
Caucasian	30%
Hispanic	70%

FUNDING SOURCES

External grants (Utah State Legislature)

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Non-classroom based
Community-based
Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Parent
Teacher
Multidisciplinary Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Interviews

CRITERIA FOR TERMINATION
Complete specified program
Poor involvement

GENERALIZATION PROCEDURES
Training in natural context
Parent training
Implementation by multiple facilitators/educators

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Rating scales

OUTCOMES THAT ARE EVALUATED
Target behaviors (problem solving)
Specific problem behaviors (child abuse issues)
Social problem solving skills
Academic functioning
Emotional well-being
Reduction in risky behavior
Self-esteem
Self-efficacy
Move or transfer to less restrictive setting
Reduction in school discipline problems
Reduction in school violence
Increase in attendance rates
Increase in graduation rates
Increase in inclusion/retention in regular education
Community outcomes

WRITTEN MATERIALS AVAILABLE

Description of program design
Program guide for implementation
Curriculum
Intervention techniques
Evaluation procedures
Evaluation results
Staff training
Intake and exit procedures
Goals and objectives
Description of program model
Definition of population served
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program implementation	80%
Program evaluation	20%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Regular Education Teachers
Special Education Teachers
School Nurse
School Administrator
Community Mental Health Agency
Parents
Program Recipients
Peers
Community Members

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on risk and protective factors

PROGRAM EVALUATION
Program integrity

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

VERMONT (VT)

Bridges Project
Montgomery Elementary School

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PROGRAM DESCRIPTION

The design of this project consists of seven components: (a) Project Advisory Council with membership from the local community, student body, faculty, school administration, and other agencies, to set project goals and initiatives; (b) Model School Site, Model School Team, and Responsive Classrooms to demonstrate to other rural schools how to fully include all children within the regular school environment; (c) School-Community Team to support the school in meeting the needs of the children; (d) Individual Student Support Teams for children and adolescents with serious emotional disturbance, to develop appropriate educational, community and family support strategies; (e) Institute to provide technical assistance for the model school site and community in Vermont to support their on-going goals and action plans; (f) evaluation/research plan with semi-structured interviews, surveys, pre- and post-intervention measures, for each component of the project to assess the impact of project activities upon educators, families, students and other community members in the model school and community site; and (g) dissemination activities through two national institutes for other rural sites, and a newsletter two times yearly. The purpose of this outreach program is to build the capacity of rural schools to include all students, including those with severe emotional disturbance, within general education and community settings through a process that promotes collaboration, emphasizes the development of shared ownership and support, and addresses the unique needs of the rural classroom, school, and community.

The school psychologist participated in all three components of program design, implementation, and evaluation. The school psychologist developed the draft of the project proposal and is responsible for training, supervising and implementing project objectives. The school psychologist also is responsible for the coordination and administration of the evaluation and dissemination of the results. Bridges Project has collected evaluation data from parents, teachers, school teams, and students throughout the school year. Data collection techniques included interviews and surveys. Qualitative analysis of the data revealed an overall satisfaction with the program from parents, teachers, and students. All participants felt that they had acquired knowledge regarding inclusion, exposure to different perspectives and attitudes, and were empowered by this experience.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Public school
POPULATION	
Age	5-22
Grade	Preschool through high school
Gender	50% female, 50% male
Racial/ethnic composition	
Caucasian	99%
Hispanic	1%

FUNDING SOURCES

External grants (U.S. Department of Education)
School funded
Funded with special education funds
Funded as non-special education support services

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems

- Prevent exacerbation of mild adjustment difficulties
- Increase social problem solving skills
- Teach conflict resolution or mediation skills
- Increase self-efficacy
- Foster appropriate expression of emotions
- Crisis intervention
- Violence prevention
- Improve academic functioning
- Support school transitions
- Parental involvement
- Risk reduction
- Generalization of program effects
- Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
- Individual
- Large group
- Classroom-based
- Non-classroom based
- School-wide

COMPONENTS
- Staff training
- Ongoing consultation with program staff
- Obtain written consent
- Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
- Parent
- Teacher
- Multidisciplinary Team
- Prereferral Intervention Team

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
- Direct observation
- Behavioral checklists
- Multiple levels of screening
- Standardized tests
- interviews

GENERALIZATION PROCEDURES
- Training in natural context
- Teaching self-monitoring or verbal mediators
- Reinforcement in other settings
- Training in multiple settings
- Parent training
- Teacher training
- Implementation by multiple facilitators/educators

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
- Observation
- Interview
- Self-report
- Rating scales
- Standardized tests

OUTCOMES THAT ARE EVALUATED
- Attitudes/beliefs
- Target behaviors (individualized education plan)
- Specific problem behaviors (individualized education plan)
- Academic functioning
- Social skills
- Emotional well-being
- Self-esteem
- Reduction in school discipline problems
- Reduction in school violence
- Increase in attendance rates
- Increase in inclusion/retention in regular education

WRITTEN MATERIALS AVAILABLE

- Description of theoretical-empirical model
- Description of program design
- Program guide for implementation
- Intervention techniques
- Evaluation procedures
- Goals and objectives
- Description of program model
- Definition of population served

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	5%
Program implementation	60%
Program evaluation	35%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
- School Psychologist
- Certified Social Worker
- Certified Counselor
- Regular Education Teachers

Special Education Teachers
School Nurse
School Administrator
School Board Member
Community Mental Health Agency
Paraprofessionals
Parents
Program Recipients
Peers
Community Members

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on program efficacy
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION
Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level II.	Early intervention
Level IV.	Treatment

Vermont State Agency of Human Services Department of Developmental and Mental Health Services: Success Beyond Six

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PROGRAM DESCRIPTION

Success Beyond Six is a flexible model for providing a variety of mental health services in schools, with case management being the core service. It has been shown to work well for children and families needing home-school coordination and intensive behavioral management at school and home. Participating schools and mental health centers jointly hire staff who serve as clinicians, social workers, or home-school coordinators for youth with severe emotional disturbance. The mental health staff works in partnership with the schools to provide and link children and their families with an array of mental health and other community-based services, including individual, group, and family psychotherapy/counseling; case management; and specialized rehabilitation services (including social support). Success Beyond Six maximizes the use of Medicaid funds and has greatly increased the capacity of schools to provide early intervention for children with emotional and behavioral problems. During the 1996-1997 school year, the program employed over 90 full-time mental health clinicians or home-school coordinators in the Vermont schools. The school psychologist, depending on the supervisory union, may be involved in program design, implementation, and evaluation.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school, private school, school health clinic, school-linked clinic, community mental health agency, day care center

POPULATION	
#students/clients	1,729
Age	Birth to adult
Grade	Preschool through high school
Gender	41% female, 59% male
Racial/ethnic composition	
African American	1%
Caucasian	93%
Native American	1%
Other	5%

FUNDING SOURCES

School funded
School mandated
Linked to school-based health clinic
Funded with special education funds
Funded as non-special education support services
Funding from private agencies
Medicaid

PROGRAM GOALS

Prevent placement in more restrictive setting
Reduce specific behavioral problems
Crisis intervention
Dropout prevention
Improve academic functioning
Parental involvement
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Large group
Classroom-based
Non-classroom based
Community-based
Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent

REFERRAL SOURCES
Multidisciplinary team
Prereferral intervention team
Mental health support staff (psychologist, counselor, social worker)

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Interviews

CRITERIA FOR TERMINATION
Meet outcome criteria
Completion of school year

GENERALIZATION PROCEDURES
Teaching self-monitoring or verbal mediators
Parent training
Teacher training

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Anecdotal records
Surveys

OUTCOMES THAT ARE EVALUATED
Target behaviors (school attendance)
Specific problem behaviors (fighting)
Academic functioning
Reduction in school discipline problems
Increase in attendance rates
Parent/teacher/student satisfaction

WRITTEN MATERIALS AVAILABLE

Description of program design
Program guide for implementation
Evaluation procedures
Evaluation results
Goals and objectives
Description of program model
Definition of population served

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)
Program design/planning *
Program implementation *
Program evaluation *
*Percentages vary depending on the particular supervisory union

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Certified Social Worker
Certified Counselor
Regular Education Teachers
Special Education Teachers
School Administrator
School Board Member
Parents
Program Recipients
Peers

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on program efficacy

PROGRAM EVALUATION

Program acceptability
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

VIRGINIA (VA)

City of Norfolk
Norfolk Interagency Consortium (NIC)

Lynn Moore
Administrator
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Norfolk, VA 23510
757-441-2501 (Phone)
757-441-2805 (Fax)

PROGRAM DESCRIPTION

The Norfolk Interagency Consortium (NIC) is designed to serve the community's most needy children and families. All major youth-serving public agencies, parents, citizens, and private providers participate in interagency teams. These teams are child-centered, family-focused, and community-based. The belief in least restrictive services is a cornerstone of the operational foundation. NIC serves approximately 800 children and their families each year, including children with foster care, special education, juvenile court, and mental health needs. The school psychologists serve as members of the interagency teams.

PROGRAM DEMOGRAPHICS

AGENCY TYPE:	Interagency teams
POPULATION	
# students/clients	741
Age	Birth-22
Gender	39% female, 61% male
Racial/ethnic composition	
African American	73%
Asian	1%
Caucasian	24%
Hispanic	1%
Other	1%

FUNDING SOURCES

State and local funds

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Classroom-based
Non-classroom based
Community-based
Home-based

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Multidisciplinary team
Outside agency

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Predetermined criteria

CRITERIA FOR TERMINATION
Meet outcome criteria
Complete specified program

GENERALIZATION PROCEDURES
Training or referral and operational process

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Target behaviors
Specific problem behaviors
Reduction in risky behavior
Move or transfer to less restrictive setting
Reduction in school discipline problems
Increase in attendance rates
Lower rate of hospitalization

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Program guide for implementation
Cost-benefit analysis
Staff training
Intake and exit procedures
Goals and objectives
Description of program model
Definition of population served
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Certified Social Worker
Community Mental Health Agency
Parents
Program Recipients
Community Members

THEORETICAL BASE
Single (ecological)

EMPIRICAL BASE
Research on population needs
Research on risk and protective factors

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level III.	Early intervention
Level IV.	Treatment

Neuropsychiatric Program Team 8 Cumberland Hospital for Children and Adolescents

Isaac K. Wood, M.D.
Neuropsychiatrist
Medical Director of Residential Services
Peggy Hicks, Ed.D., NCSP
Post Doctoral Fellow in Clinical Neuropsychology (1994-1996)
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New Kent, VA 23124
800-368-3472 (Phone)
804-966-2242 (Phone)
804-966-5639 (Fax)

PROGRAM DESCRIPTION

Team 8 provides an innovative nontraditional approach to providing treatment for difficult-to-treat youth, ages 13 to 17 years, with diagnoses of Conduct Disorder-Childhood onset and Attention Deficit Hyperactivity Disorder with accompanying history of aggression. Treatment is multisystemic, focusing on the youth, their families, peers, school, and home community, and using multiple treatment modalities. In contrast to most residential treatment programs, Team 8 never completely severes the ties between the residential setting, the family, and community of origin. Planning for community re-entry starts at admission and in-vivo family therapy serves to empower the parents on their own turf. Further, transition planning assures that community reintegration is a process and not an event.

Interventions are designed to promote responsible behavior and reduce conflictual interactions between family members. Interventions are present-focused and action-oriented, targeting specific and well-defined problems and target sequences of behavior within or between multiple systems. The overriding goal of Team 8 professionals is to empower parents with the skills and resources to independently address the inevitable difficulties that arise in raising children and to empower youth to cope reasonably with the many stressors in their lives. Scott Henggeler's (1986) Multisystemic Family Therapy Model (MST) of treatment serves as a theoretical foundation for Team 8's service delivery system. A review of the literature provides a strong foundation in outcome research studies documenting the effectiveness of Multisystemic therapy.

The neuropsychologist/school psychologist has been involved in program modifications, implementation, and evaluation. Her responsibilities include providing direct services such as psychotherapy, neuropsychological assessment, case management, and program development activities. Program development activities include program revisions, program evaluation, and developing a clinical data base.

At its inception, Team 8 incorporated a comprehensive plan for program evaluation providing a variety of outcome measures. Formal data collection begins prior to admission with completion of the Application for Admission by the referral source. Historical evidence is combined with the Psychosocial Evaluation and behavioral data collected on the unit to develop goals for the resident's behavioral program and treatment plan. Outcome measures collected at various points in the course of treatment and after care, includes an initial assessment, assessment at discharge, and follow-up survey. A follow-up assessment is made by telephone survey, 3 and 12 months post-discharge. Patient satisfaction also is surveyed by phone after discharge. The Gallop Corporation is responsible for making the telephone calls, providing reports, and data files. In an attempt to convert data into usable information, collaborative relationships have been forged with other members of the Brown School scattered across the country to increase the data pool.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Private rehabilitation hospital, proprietary school

POPULATION

# students/clients	12
Age	13-17
Grade	junior high school, high school, other (ungraded)
Gender	100% male
Racial/ethnic composition	
African American	78%
Caucasian	22%

FUNDING SOURCES

School funded
School mandated
Funded with special education funds
Funding from private agencies (Healthcare America)
Medicaid
Private insurance
Community Service Board Residential Placement Unit

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Increase participation in regular education
Reduce specific behavioral problems
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Increase parental involvement
Generalization of program effects
Individualized goals
Decrease out-of-home placements

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Classroom-based
Non-classroom based
School-wide
Community-based
Home-based
Related services

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent

Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Multidisplinary team (schools and public agencies)
Outside agency

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Multiple levels of screening
Standardized tests
Interviews

CRITERIA FOR TERMINATION
Meet outcome criteria
Attrition

ATTRITION RATE: 37.5% (premature discharges)

GENERALIZATION PROCEDURES
Training in natural context
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Training in multiple settings
Parent training
Teacher training
Implementation by multiple facilitators/educators
In-vivo family therapy

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Self-report
Rating scales
Standardized tests
Anecdotal records
Medical history

OUTCOMES THAT ARE EVALUATED
Target behaviors (aggression)
Specific problem behaviors (legal involvement; out of home placement; opposition/defiance)
Social problem solving skills
Academic functioning
Social skills
Emotional well-being
Reduction in risky behavior (impulsivity)
Self-efficacy
Generalization of program effects to other settings
Maintenance of program effects
Move or transfer to less restrictive setting
Reduction in school discipline problems
Increase in attendance rates
Increase in graduation rates
Increase in inclusion/retention in regular education
Reduction in special education placements
Lower rate of hospitalization (recidivism)
Community outcomes (court involvement)
Social involvement/withdrawal

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Program guide for implementation
Curriculum
Intervention techniques
Evaluation procedures
Evaluation results
Cost-benefit analysis
Staff training
Intake and exit procedures
Procedures for insuring generalization of program effects
Goals and objectives
Theoretical-empirical foundation
Description of program model
Definition of population served
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program design/planning	20%
Program implementation	62%
Program evaluation	18%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist/Neuropsychologist
Certified Social Worker
Special Education Teachers
Nurse

Clinical Supervisor
Program Director
Recreation Therapist
Speech/Language Therapist
Neuropsychiatrist
Community Mental Health Agency
Paraprofessionals (Behavior Coach)
Teaching Assistant
Parents
Program recipients
Peers
Community members

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on program efficacy
Research on population needs
Research on risk and protective factors
Medical research

PROGRAM EVALUATION

Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level IV	Treatment

WASHINGTON (WA)

Point Defiance Family Support Center
Tacoma Public Schools

Keith S. Mars, Ph.D., NCSP
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Point Defiance Elementary School
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PROGRAM DESCRIPTION

The Family Support Center serves the Point Defiance community in Tacoma, Washington, surrounding Point Defiance School. A little more than one-third of the children served by the school come from homes characterized by poverty, high transiency, and single parenting. The families in Point Defiance neighborhood have minimal support services within close proximity. These conditions pose a significant public health problem. The purpose of Family Support Center is to address public health problems resulting from non-fatal abuse and neglect (e.g., developmental delays, brain damage, physical and sensory disabilities, acute and chronic physical and mental health problems, future misuse of alcohol and other drugs, academic failure and other serious consequences). The Center is primarily a prevention-oriented program, but also delivers direct services as needed. The focus is on children from 0-12 years old. A Parent or Community Advisory Council has been established to assure the services are community-driven. The mental health component was the first component established and continues to provide a range of mental health and family counseling services. The school psychologist developed the Family Support Center to include co-location and partnership of on-site service providers at the school, including providers from the Health Department, several social service agencies, the Community Mental Health Center, and Child Protective Services. The school psychologist coordinates all school-based program activities.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school, community mental health agency, health department

POPULATION

# students/clients	60 families
Age	The focus is on children from birth to 12 years and their families
Grade	Head Start through middle school
Gender	50% female, 50% male

Racial/ethnic composition

African American	20%
Asian	2%
Caucasian	77%
Hispanic	1%

FUNDING SOURCES

External grants (consortium of community agencies- Boeing, United Way, etc.)
School funded
Funded as non-special education support services
Funding from private agencies

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Support school transitions
Parental involvement
Risk reduction
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Small group
Non-classroom based
School-wide
Community-based
Home-based
Community education classes
Summer activities

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Self
Parent
Teacher
Multidisciplinary Team
Prereferral Intervention Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)
School Nurse
Outside Agency

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Interviews

CRITERIA FOR TERMINATION
Mutual agreement that services are no longer needed

GENERALIZATION PROCEDURES
Training in natural context
Teaching self-monitoring or verbal mediators
Parent training
Teacher training
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Anecdotal records

OUTCOMES THAT ARE EVALUATED
Target behaviors
Social problem solving skills
Academic functioning
Social skills
Reduction in risky behavior
Self-esteem
Maintenance of program effects
Reduction in school discipline problems
Reduction in referrals to special education
Reduction in special education placements
Community outcomes (Health Department data)

WRITTEN MATERIALS AVAILABLE

Description of program design
Program guide for implementation
Goals and objectives
Description of program model
Definition of population served
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program design/planning	70%
Program implementation	25%
Program evaluation	5%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Certified Counselor
School Administrator
Community Mental Health Agency
Parents
Community Members
Public Health Department
Social Service Agencies
Safe Streets
Child Protective Services

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on risk and protective factors

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I.	Prevention
Level II.	Risk reduction
Level II.	Early intervention
Level IV.	Treatment

Restructuring School Psychological Services
Marysville Junior High School

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PROGRAM DESCRIPTION

"Restructuring School Psychological Services" involves 4 programs.

The Learning Center provides both placement and drop-in services. Students are placed there either as peer helpers (regular or special education students capable of giving assistance) or as a special education class placement. Drop-in students are either regular or special education students who come for one period for assistance with a test or assignment or to make up work from an absence. The mix of students creates an atmosphere in which it is difficult to stigmatize or label anyone and which does not appear to be a typical special education program. Group counseling is provided twice weekly for all students placed in the Learning Center. All groups include at least two behavioral disability students (at least one acting-out and one withdrawn student) and at least two peer helpers, as well as numerous other students. The focus is on developing communication skills and teaching students to confront each others' behavior in constructive or helpful ways.

The Support Room is a low-level discipline intervention for minor classroom misbehavior. If teacher interventions are not effective, a student may be removed, with an escort, to the Support Room for the remainder of that class period. No further discipline referrals are made as long as the student follows the rules in Support. This avoids overcrowding the office with minor discipline problems.

All-School Social Skills Lessons consist of video-taped lessons on a wide range of topics, constructed by students and shown on an all-school TV channel. These lessons have been effective in improving behavior.

Conflict Managers Program. Conflict managers are students who are trained by the school psychologist and help others manage conflict.

The school psychologist was directly involved in changing the school climate and facilitating the learning and adjustment of at-risk students. Involvement in these efforts resulted in restructuring of the school psychologist's role. As a result of these program efforts, the school's discipline problems have been reduced by 50%.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public School

POPULATION

Learning Center (Placement)

# students/clients	86 (over 2 years)
Age	13-16
Grades	8-9
Gender	40% female, 60% male
Racial/ethnic composition	
African American	5%
Asian	10%
Caucasian	65%
Native American	
Caribbean,	
Jamaican,	20%
West Indian	1%

Learning Center (Drop-In)

# students/clients	474 (over 2 years)
Ages	13-16
Grades	8- 9
Gender	40% female, 60% male

Racial/ethnic composition	
African American	1%
Asian	1%
Caucasian	80%
Hispanic	1%
Native American	16%
West Indies	1%

Support Room

# students/clients	374 (over 2 years)
Ages	13-16
Grades	8-9
Gender	20% female, 80% male
Racial/ethnic composition	
African American	5%
Asian	10%
Caucasian	65%
Native American	20%

All-School Social Skills Lessons

# students/clients	975 (over 2 years)
Ages	13-16
Grades	8-9
Gender	50% female, 50% male
Racial/ethnic composition	
African American	5%
Asian	10%
Caucasian	65%
Native American	20%

Conflict Managers Program

#students/clients	124 (over 2 years)
Ages	13-16
Grades	8-9
Gender	40% female, 60% male
Racial/ethnic composition	
African American	5%
Asian	10%
Caucasian	65%
Native American	20%

FUNDING SOURCES

External grants (State crime prevention and student learning improvement grants)
Funded with special education funds

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Reduce referrals to special education
Prevent exacerbation of mild adjustment difficulties
Individualized goals (if the student has an IEP)

PROGRAM IMPLEMENTATION

Learning Center (Placement)

FORMAT
Individual
Small group
Large group
Classroom-based
Non-classroom based

COMPONENTS
Ongoing consultation with program staff
Obtain written consent
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Self
Teacher
Multidisplinary Team
Prereferral Intervention Team
Mental Health Support Staff (Psychologist, Counselor, Social Worker)

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Interviews

CRITERIA FOR TERMINATION
Complete specified program

Learning Center (Drop-In)

FORMAT
Small group
Non-classroom based

COMPONENTS
Staff training
Ongoing consultation with program staff

REFERRAL SOURCES
Self
Teacher

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Teacher or self-referral

CRITERIA FOR TERMINATION
Self-satisfaction with work or completed teacher-assigned work

Support Room

FORMAT
Individual
Non-classroom based

REFERRAL SOURCES
Teacher

CRITERIA FOR TERMINATION
End of period

All-School Social Skills Lessons

FORMAT
School-wide

COMPONENTS
Staff training
Access additional resources (e.g., funding, staff)

CRITERIA FOR TERMINATION
Complete specified program

GENERALIZATION PROCEDURES
Reinforcement in other settings
Implementation by multiple facilitators/educators

Conflict Managers Program

FORMAT
Individual
Small group
Classroom-based

COMPONENTS
Staff training
Student training
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Self
Mental Health Support Staff (Counselor)
School Discipline Officer

CRITERIA FOR TERMINATION
Meet outcome criteria
Complete specified program
Deemed inappropriate for program
Disputants sign an agreement, ending the dispute

GENERALIZATION PROCEDURES
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Interview
Self-report
Anecdotal records
Other (school-wide discipline data)

OUTCOMES THAT ARE EVALUATED
Reduction in school discipline problems
Reduction in school violence
Increase in inclusion/retention in regular education

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Evaluation procedures
Evaluation results

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	10%
Program implementation	80%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Special Education Teachers
Paraprofessionals
Program Recipients
Peers

THEORETICAL BASE

Multiple

EMPIRICAL BASE

Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION
Program acceptability
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I	Prevention
Level IV	Treatment

WISCONSIN (WI)

The Violence Prevention Program Milwaukee Public Schools Department of School Psychological Services

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PROGRAM DESCRIPTION

The Violence Prevention Program was developed in 1987 to provide students and staff with functional skills in problem-solving, anger management, and alternative strategies for dealing with potentially violent situations. The program intends to prevent or reduce negative conflict and promote qualities for healthy relationships and life styles through the following program components:

1. Managing Violent Situations (MVS) is a workshop for all school staff that teaches techniques of non-violent crisis intervention.
2. Second Step: A Violence Prevention Curriculum is a classroom-based program designed to reduce impulsive and aggressive behavior, and increase social competence.
3. Peer Mediation, a conflict resolution approach, provides an opportunity for students to assist others in negotiating constructive solutions.
4. Parent Workshops deal with effective non-violent discipline strategies.
5. Students Against Violence Groups promotes a proactive stance against aggression
6. Discipline with Dignity (developed by Dr. Richard Curwin) is a workshop on disciplinary methods that teaches responsibility and preserves dignity.

The school psychologists on the Violence Prevention Program are involved in design, implementation, and evaluation. The program personnel, which consists of four school psychologists, work in collaboration with school-based teams to plan implementation strategies that address the specific needs of the school. The school-based school psychologists support the Violent Prevention facilitators in implementing the program.

The Program staff have surveyed principals and groups of teachers at the schools in which the workshops and curricular training have taken place. Results indicate that the program has been deemed effective by those who have used it. Teachers and principals concurred that the students had benefited from the use of the program. Specific findings follow.

1. 92% of all principals agreed or strongly agreed that the program had a positive impact on building climate.
2. 87% of teachers in classrooms where Second Step was consistently used reported that they had observed an improvement in students' communication skills and behavior.
3. 84% of responding principals noted decreased classroom behavior problems.
4. 88% of teachers and principals agreed that peer mediation was viewed by students and staff as a useful tool for conflict management.

The Violence Prevention Program in conjunction with the Educational Psychology Department at UW-Milwaukee are completing a two-year research project on the effectiveness of the Second Step Curriculum as a primary prevention tool.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school

POPULATION

# students/clients	100,000
Age	3-18+
Grade	preschool through high school
Gender	50% female, 50% male

Racial/ethnic composition

African American	60%
Asian	.5%
Caucasian	30%
Hispanic	10%
Native American	.1%

FUNDING SOURCES

School funded
Funded as special education support services

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills
Increase self-efficacy
Foster appropriate expression of emotions
Crisis intervention
Violence prevention
Improve academic functioning
Parental involvement
Risk reduction
Generalization of program effects

PROGRAM IMPLEMENTATION

FORMAT
Large group
Classroom-based
School-wide
District-wide

COMPONENTS
Staff training
Ongoing consultation with program staff
Access additional resources (e.g., funding, staff)

REFERRAL SOURCES
Administrator

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
All students receive services

CRITERIA FOR TERMINATION
Program on-going

GENERALIZATION PROCEDURES
Training in natural context
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Parent training
Teacher training
Implementation by multiple facilitators/educators
Booster or follow-up sessions

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Observation
Interview
Self-report
Rating scales

OUTCOMES THAT ARE EVALUATED
Knowledge
Attitudes/beliefs
Target behaviors
Specific problem behaviors
Social problem solving skills
Social skills
Emotional well-being
Reduction in risky behavior
Generalization of program effects to other settings
Maintenance of program effects
Reduction in school discipline problems
Reduction in school violence

WRITTEN MATERIALS AVAILABLE

Description of program design
Curriculum

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT
(How does the school psychologist allocate his/her program time?)

Program design/planning	30%
Program implementation	60%
Program evaluation	10%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*
School Psychologist
Regular Education Teachers
Special Education Teachers
School Administrator

THEORETICAL BASE
Multiple

EMPIRICAL BASE
Research on population needs
Research on risk and protective factors

PROGRAM EVALUATION
Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I	Prevention
Level II	Risk reduction
Level III	Early intervention

WYOMING (WY)

Combined Class Model at McKinley Elementary School
Natrona County School District No.1
Pupil Services
Wyoming School for the Deaf

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PROGRAM DESCRIPTION

The Combined Classroom (CC) is specifically designed to create the opportunity for well adjusted students, through peer modeling and peer reinforcement, to play an important role in helping students with Emotional Behavioral Disorder (EBD) to make improved behavioral choices. The instructional components of the CC include: (a) School district grade level appropriate curriculum for all students and Individualized Educational Plans (IEP) for students with disabilities; (b) Integrated Classroom Behavior Management Plan; (c) Social Skills Component; (d) Building-wide Crisis Management Plan; and (e) Mental Health Component. The primary goal for students with EBD is to improve problem behaviors in the areas leading to classification as EBD. Long-term goals include: (a) successful re-integration of more students with EBD into traditional general education settings; (b) decrease the percentage of students with EBD who need self-contained placements; and (c) increase the percentage of students with EBD who graduate high school. The school psychologist was involved in the design, implementation, and evaluation of the program and is a member of the Support Team. Parent and student satisfaction data support conclusions that these services are highly desired and acceptable. Formative data regarding student academic and behavioral performance have been encouraging and provide support for the continuation of the existing program and the eventual expansion of the design to other sites. Pilot-year outcomes include:

1. The inclusion of students with EBD in the CC was not associated with a negative impact upon the standing of other students in the CC.
2. The students without EBD who attended the pilot CC maintained their school behavior grades while the three students with EBD improved their school behavior grades.
3. Students reported increased empathy and CC teachers indicated fewer behavior problems for students with EBD compared to previous teacher reports.
4. The parents of the students with EBD were unanimous in their strong support for the program. The majority of parents of general students (59%) expressed strong satisfaction. The level of student dissatisfaction was minimal.

PROGRAM DEMOGRAPHICS

AGENCY TYPE: Public school, community mental health agency

POPULATION

# students/clients	No more than 32 at any given time
Age	9-12
Grade	elementary school
Gender	43% female, 57% male

Racial/ethnic composition (The percentages are approximate due to variation over time)

African American	4%
Caucasian	88%
Hispanic	8%

FUNDING SOURCES

School funded (through special education and general education funds)
Funded with special education funds
Funded as non-special education support services

PROGRAM GOALS

Enhance social competence
Teach specific social skills
Increase self-esteem
Increase participation in regular education
Prevent placement in more restrictive setting
Reduce specific behavioral problems
Prevent exacerbation of mild adjustment difficulties
Increase social problem solving skills
Teach conflict resolution or mediation skills

Increase self-efficacy
Crisis intervention
Violence prevention
Dropout prevention
Improve academic functioning
Risk reduction
Generalization of program effects
Individualized goals

PROGRAM IMPLEMENTATION

FORMAT
Individual
Large group
Classroom-based
Non-classroom based
Several classrooms within a grade level

COMPONENTS
Staff training
Ongoing consultation with program staff
Obtain written consent

REFERRAL SOURCES
Parent
Teacher
Multidisplinary team

ASSESSMENT PROCEDURES TO DETERMINE ELIGIBILITY
Direct observation
Behavioral checklists
Multiple levels of screening
Standardized tests
Interviews
Response to behavioral interventions in previous settings for EBD students

CRITERIA FOR TERMINATION
IEP Team recommendations for EBD students

ATTRITION RATE: 25% (over 2 years, 25% of EBD students left the district)

GENERALIZATION PROCEDURES
Training in natural context
Teaching self-monitoring or verbal mediators
Reinforcement in other settings
Training in multiple settings
Teacher training

PROGRAM EVALUATION

DATA COLLECTION TECHNIQUES
Self-report
Rating scales
Standardized tests
Anecdotal records
Satisfaction surveys
Report cards

OUTCOMES THAT ARE EVALUATED
Knowledge
Specific problem behaviors (behavior ratings, report card behavior grades)
Academic functioning
Social skills
Increase in inclusion/retention in regular education
Parent and student satisfaction

WRITTEN MATERIALS AVAILABLE

Description of theoretical-empirical model
Description of program design
Evaluation results
Cost-benefit analysis
Staff training
Intake and exit procedures
Goals and objectives
Description of program model
Definition of population served
Eligibility criteria
Referral procedures

EXEMPLARY CHARACTERISTICS

SCHOOL PSYCHOLOGIST'S PROGRAM INVOLVEMENT

(How does the school psychologist allocate his/her program time?)

Program design/planning	50%
Program implementation	25%
Program evaluation	25%

ECOLOGICAL-COLLABORATIVE MODEL *(Program Participants)*

School Psychologist
Certified Social Worker
Counselor
Regular Education Teachers
Special Education Teachers

School Nurse
School Administrator
Educational Resource Specialist
Paraprofessionals (Teaching Assistants)

THEORETICAL BASE

Behavioral/developmental

EMPIRICAL BASE

Research on population needs
Literature on serving ED students
Data-based

PROGRAM EVALUATION

Program acceptability
Program integrity
Program efficacy (outcome)

LEVELS OF SERVICE PROVISION

Level I	Prevention
Level II	Risk reduction
Level III	Early intervention
Level IV	Treatment

REFERENCES

Adelman, H. S. (1993). School-linked mental health interventions: Toward mechanism for service coordination and integration. Journal of Community Psychology, 21(4), 309-319.

Adelman, H. S. (1996). Restructuring education support services and integrating community resources: Beyond the full service school model. School Psychology Review, 25, 431-445.

Adelman, H. S. (1995). Education reform: Broadening the focus. Psychological Science, 6(1), 61-62.

Anderson, G. L. (1989). Critical ethnography in education: Origins, current status, and new directions. Review of Educational Research, 59(3), 249-270.

Attkisson, C. C., Dresser, K. L., & Rosenblatt, A. (1995). Service systems for youth with severe emotional disorder: System of care research in California. In Bickman, L., & Rog, D. J. (Eds.), Children's mental health services: Research, policy, and evaluation. (pp. 236-277). Thousand Oaks, California: Sage Publications.

Attkisson, C. C., & Rosenblatt, A. (1993). Enhancing school performance of youth with severe emotional disorder: Initial results from system of care researching three California counties. School Psychology Quarterly, 8(4), 277-290.

Bangert-Drowns, R. L. (1988). The effects of school-based substance abuse education: A meta-analysis. Journal of Drug Education, 18(3), 243-264.

Bell, C. C., & Jenkins, E. J. (1991). Traumatic stress and children. Journal of Health Care for the Poor and Underserved, 2(1), 175-187.

Berliner, L., & Conte, J. R. (1990). The process of victimization: The victim's perspective. Child Abuse and Neglect, 14, 29-40.

Binder, R. L., & McNiel, D. E. (1987). Evaluation of a school based sexual abuse prevention program: Cognitive and emotional effects. Child Abuse and Neglect, 11, 497-506.

Blumbeg, E. J., Chadwick, M. W., Fogarty, L. A., Speth, T. W., & Chadwick, D. L. (1991). The touch discrimination component of sexual abuse prevention training: Unanticipated positive consequences. Journal of Interpersonal Violence, 6(1), 12-28.

Botvin, G. J., Baker, E., Filazzola, A. D., & Botvin, E. M. (1990). A cognitive-behavioral approach to substance abuse prevention: One-year follow-up. Addictive Behaviors, 15(1), 47-63.

Brock, S. E., Sandoval, J., & Lewis, S. (1996). Preparing for crises in the school: A manual for building school crisis response teams. Brandon, VT: Clinical Psychology Publishing Company.

Bronfenbrenner, U. (1989). Ecological systems theory. In R. Vasta (Ed.), Annals of Child Development, (Vol. 6, pp. 187-249). Greenwich, CT: JAI Press.

Browne, A., & Finkelhor, D. (1986). Initial and long term effects: A review of the research. In D. Finkelhor (Ed.), A sourcebook on child sexual abuse. (pp. 143-179). Newbury Park: California, Sage Publications.

Budin, L. E., & Johnson, C. F. (1989). Sex abuse prevention programs: Offenders attitudes about their efficacy. Child Abuse and Neglect, 13, 77-87.

Camp, B. W., & Bash, M. A. S. (1985). Think Aloud: Increasing social and cognitive skills - A problem-solving program for children. Champaign, IL: Research Press.

Caplan, G. (1964). Principles of Preventive Psychiatry. New York: Basic Books.

Carlson, C., Paavola, J., & Talley, R. (1995). Historical, current, and future models of schools in health care service delivery settings. School Psychology Quarterly, 10, 184-202.

Casey, R. J., & Berman, J. S. (1985). The outcome of psychotherapy with children. Psychological Bulletin, 98, 388-400.

Catron, T., & Weiss, B. (1994). The Vanderbilt school-based counseling program: An interagency, primary-care model of mental health services. Special Series: Center for Mental Health Services Research Projects. Journal of Emotional and Behavioral Disorders, 2(4), 247-253.

Chandler, C. L., Weissberg, R. P., Cowen, E. L., & Guare, J. (1984). Long-term effects of a school-based secondary prevention program for young maladapting children. Journal of Consulting and Clinical Psychology, 52(2), 165-170.

Cheramie, G. M., & Sutter, E. G. (1993). Role expansion in school psychology: The need for primary and secondary prevention services. Psychology in the Schools, 30, 53-59.

Christenson, S. L., & Cleary, M. (1990). Consultation and the parent-educator partnership: A perspective. Journal of Educational and Psychological Consultation, 1, 219-241.

Christenson, S. L., & Conoley, J.C. (1992). (Eds.). Home-school collaboration: Building a fundamental educational resource. Silver Springs, MD: National Association of School Psychologists.

Ciffone, J. (1993). Suicide prevention: A classroom presentation to adolescents. Social Work, 38(2), 197-203.

Curtis, M. J. & Stollar, S. A. (1996). Applying principles and practices of organizational change to school reform. School Psychology Review, 25, 409-417.

Deutsch, M. (1993). Educating for a peaceful world. American Psychologist, 48, 510-517.

Doll, B. (1996). Prevalence of psychiatric disorders in children and youth: An agenda for advocacy by school psychology. School Psychology Quarterly, 11, 20-47.

Durlak, J. A. (1983). Social problem-solving as a primary prevention strategy. In R. D. Felner, L. A. Jason, J. N. Moritsugu, & S. S. Farber (Eds.), Preventive Psychology: Theory, research and practice, (pp. 31-48). New York: Pergamon Press.

Elias, M. J., & Branden, L. R. (1988). Primary prevention of behavioral and emotional problems in school-aged populations. School Psychology Review, 17, 581-592.

Elliott, M., Browne, K., & Kilcoyne, J. (1995). Child sexual abuse prevention: What offenders tell us. Child Abuse and Neglect, 19(5), 579-594.

Elliott, S. N., Witt, J. C., & Kratochwill, T. R. (1991). Selecting, implementing, and evaluating classroom interventions. In G. Stoner, M. R. Shinn, & H. M. Walker (Eds.), Interventions for achievement and behavior problems (pp. 99-135). Silver Spring, MD: The National Association of School Psychologists.

Felner, R. D., Norton, P. L., Cowen, E. L, & Farber, S. S (1981). A prevention program for children experiencing life crisis. Professional Psychology, 12, (4), 446-452.

Finkelhor, D., Asdigian, N., & Dziuba-Leatherman, J. (1995). The effectiveness of victimization prevention instruction: An evaluation of children's responses to actual threats and assaults. Child Abuse and Neglect, 19(2), 141-153.

Gesten, E. L., & Weissberg, R. P. (1986). Social problem-solving with children: A guide to effective practice. Special Services in the Schools, 2(4), 19-38.

Gilchrist, L. D., Schinke, S. P., Trimble, J. E., & Cvetkovich, G. T. (1987). Skills enhancement to prevent substance abuse among American Indian adolescents. International Journal of the Addictions, 22(9), 869-879.

Glazer, S. (1992). Violence in schools. Congress Quarterly Research, 2(34), 785-808.

Goldstein, A. P. (1988). The Prepare Curriculum: Teaching prosocial competencies. Champaign, IL: Research Press.

Goldstein, A. P., Glick, B., Reiner, Reiner, S., Zimmerman, D., & Coultry, T. M. (1987). Aggression replacement training. Champagne, Il: Research Press.

Goldstein, A. P., & Huff, C. R. (Eds.). (1993). The gang intervention book. Champagne, Il: Research Press.

Grych, J. H., & Fincham, F. D. (1992). Interventions for children of divorce: Toward greater integration of research and action. Psychological Bulletin, 111, 434-453.

Guidubaldi, J., Perry, J. D., & Nastasi, B. K. (1987). Assessment and intervention for children of divorce: Implications of the NASP-KSU Nationwide Study. In J. P. Vincent (Ed.), Advances in family intervention, assessment and theory: A research annual (Vol. 4), pp. 33-69. Greenwich, CT: JAI Press.

Gutkin, T. B., Henning-Stout, M., & Piersel, W. C. (1988). Impact of a district-wide behavioral consultation prereferral intervention service on patterns of school psychological service delivery. Professional School Psychology, 3, 301-308.

Harvey, P., Forehand, R., Brown, C., & Holmes, T. (1988). The prevention of sexual abuse: Examination of effectiveness of a program with kindergarten age children. Behavior Therapy, 19, 429-435.

Health, Education, and Human Services Division. (1995). School safety: Promising initiatives for addressing school violence. Report to the ranking minority member, Subcommittee on Children and Families, Committee on Labor and Human Resources, U.S. Senate (Report No. GAO-HEHS-95-106). Washington, DC: General Accounting Office. (ERIC Document Reproduction Service No. ED 384 125)

Herbert, M. (1989). The Fairfax County suicide prevention program: A public school system responds. Residential Treatment for Children and Youth, 7(1), 89-96.

Howerton, D. L., & Enger, J. M. (1994). School characteristics related to principals' perceived needs for a violence prevention program in the Arkansas Delta. Nashville, TN: Mid-South Educational Research Association. (ERIC Document Reproduction Service No. ED 384 109)

Johnson, D. W., & Johnson, R. T. (1983). The socialization and achievement crisis: Are cooperative learning experiences the solution? Applied Social Psychology Annual, 4, 119-164.

Johnson, D. W., Johnson, R. T., & Dudley, B. (1991). Effects of peer mediation on elementary school students . Minneapolis, MN: Cooperative Learning Center.

Johnson, D. W., Johnson, R., Dudley, B., & Acikgoz, K. (1991). Peer mediation: Effects of conflict resolution training on elementary school students: Minneapolis, MN: Cooperative Learning Center.

Johnson, D. W., Johnson, R. T., Dudley, B., & Burnett, R. (1991). Peer mediation of student conflicts: A self-discipline school program: Minneapolis, MN: Cooperative Learning Center.

Jordan, P. D., & Hernandez, M. (1990). The Ventura Planning Model: A proposal for mental health reform. Journal of Mental Health Administration, 17(1), 26-47.

Kalafat, J., & Elias, M. (1994). An evaluation of a school-based suicide awareness intervention. Suicide and Life-Threatening Behavior, 24(3), 224-233.

Kazdin, A. E., French, N. H., & Sherick, R. B. (1981). Acceptability of alternative treatments for children: Evaluations by inpatient children, parents, and staff. Journal of Consulting and Clinical Psychology, 49(6), 900-907.

Kaufman, K. L., Harbeck-Weber, C., & Rudy, L. (1994). Re-examining the efficacy of child sexual abuse prevention strategies: Victims' and offenders' attitudes. Child Abuse and Neglect, 18(4), 349-356.

Klingman, A. (1987). A school-based emergency crisis intervention in a mass school disaster. Professional Psychology: Research and Practice, 18, (6), 604-612.

Klingman, A. (1989). School-based emergency intervention following an adolescent's suicide. Death Studies, 13, 263-274.

Knoff, H. M. (1996). The interface of school, community, and health care reform: Organizational directions toward effective services for children and youth. School Psychology Review, 25, 446-464.

Knoff, H. M. & Curtis, M. J. (1996). Introduction to mini-series: Organizational change and school reform: School psychology at a professional crossroad. School Psychology Review, 25- 406-408.

Knoff, H. M., Curtis, M. J., & Batsche, G. M. (1997). The future of school psychology: Perspectives on effective training. School Psychology Review, 26, 93-103.

Kolko, D. J., Moser, J. T., Litz, J., & Hughes, J. (1987). Promoting awareness and prevention of child sexual victimization using the "Red Flag/Green Flag Program": An evaluation with follow-up. Journal of Family Violence, 2(1), 11-35.

Kolko, D. J., Witte, S. S., & Fryer, G. E. (1989). Classroom training in sexual victimization awareness and prevention skills: An extension of the "Red Flag/Green Flag People Program." Journal of Family Violence, 4(1) 25-45.

Levitt, E. E. (1957). The results of psychotherapy with children: An evaluation. Journal of Consulting Psychology, 21, 189-196.

Malley, P. B., Kush, F., & Bogo, R. J. (1994). School-based adolescent suicide prevention and intervention programs: A survey. The School Counselor, 42, 130-136.

Martin, D., Martin, M., & Barrett, C. (1987). A peer counselor crisis intervention training program to help prevent adolescent suicide. Techniques, 3(3), 214-218.

Mattison, R. E., Morales, J., & Bauer, M. A. (1992). Distinguishing characteristics of elementary schoolboys recommended for SED placement. Behavioral Disorders, 17(2), 107-114.

Meyers, J., & Nastasi, B. K. (In press). Primary prevention in school settings. In C. R. Reynolds & T. B. Gutkin (Eds.), Handbook of School Psychology (3rd ed.). NY: Wiley.

Mowder, B. A., Widerstrom, A. H., & Sandall, S. (1989). School psychologists serving at-risk and handicapped infants, toddlers, and their families. Professional School Psychology, 4, 159-171.

Nastasi, B. K. (1995). Is early identification of children of alcoholics necessary for preventive intervention? Reaction to Havey and Dodd. Journal of School Psychology, 33(4), 327-345.

Nastasi, B. K., & Clements, D. H. (1991). Research on cooperative learning: Implications for practice. School Psychology Review, 20, 110-131.

Nastasi, B. K., & Clements, D. H. (1992). Social-cognitive behaviors and higher-order thinking in educational computer environments. Learning and Instruction, 2, 215-238.

Nastasi, B. K., Clements, D. H., & Battista, M. T. (1990). Social-cognitive interactions, motivation, and cognitive growth in Logo programming and CAI problem-solving environments. Journal of Educational Psychology, 82, 150-158.

Nastasi, B. K., & DeZolt, D. M. (1994). School interventions for children of alcoholics. NY: Guilford.

Nastasi, B. K., Schensul, J. J., Sivayoganathan, C., & Varjas, K. (1997). Community-based HIV/AIDS prevention program for Sri Lankan youth. Unpublished manuscript. University at Albany, State University of New York.

Nastasi, B. K., Schensul, S. L., & Varjas, K. (1996, March). Heterosexual decision-making of young women in Sri Lanka: A model for AIDS prevention. Paper presented at the annual meeting of the Society for Applied Anthropology, Seattle.

National Advisory Mental Health Council. (1990). National plan for research on child and adolescent mental disorders. Washington, DC: National Institute of Mental Health.

Nelson, F. L. (1987). Evaluation of a youth suicide prevention school program. Adolescence, 22(88), 813-825.

Norris, D.A., Burke, J. P., & Speer, A. L. (1990). Tri-level service delivery: An alternative consultation model. School Psychology Quarterly, 5, 89-110.

Oden, S. (1986). Developing social skills instruction for peer interaction and relationships. In G. Carledge & J. F. Milburn (Eds.), Teaching social skills to children: Innovative approaches (2nd ed., pp. 246-269). New York: Pergamon Press.

Offord, D. R., Boyle, M. H., Szatmari, P., Rai-Grant, N. I., Links, P. S., Cadman, D. T., Byles, J. A., Crawford, J. W., Blum, H. M., Byrne, C., Thomas, H., & Woodward, C. A. (1987). Ontario child health study. Archives of General Psychiatry, 44, 832-855.

Partridge, W. L. (1985). Toward a theory of practice. American Behavioral Scientist, 29(2), 139-163.

Pedro-Carroll, J. L., & Cowen, E. L. (1985). The children of divorce intervention project: An investigation of the efficacy of a school-based prevention program. Journal of Consulting and Clinical Psychology, 53, 603-611.

Pellegrini, D. S., & Urbain, E. S. (1985). An evaluation of interpersonal cognitive problem solving training with children. Journal of Child Psychology and Psychiatry and Allied Disciplines, 26(1), 17-41.

Pentz, M. A. (1985). Social competence and self-efficacy as determinants of substance abuse in adolescence. In S. Shiffman & T. A. Wills (Eds.), Coping and substance use (pp. 117-142). Orlando, FL: Academic Press.

Pitchner, G., & Poland, S. (1992). Crisis Intervention in the Schools. New York: Guildford.

Pouche, C., Yoder, P., & Miltenberger, R. (1988). Teaching self-protection to children using television techniques. Journal of Applied Behavior Analysis, 21, 253-261.

Prout, H. T., & DeMartino, R. A. (1986). A meta-analysis of school based studies of psychotherapy. Journal of School Psychology, 24, 285-292.

Reschly, D. J. (1988). Special education reform: School psychology revolution. School Psychology Review, 17, 459-475.

Reschly, D. J., & Wilson, M. S. (1995). School psychology practitioners and faculty: 1986 to 1991-92 trends in demographics, roles, satisfaction, and system reform. School Psychology Review, 24, 62-80.

Roberts, A. H., & Rust, J. O. (1994). Role and function of school psychologists, 1992-93: A comparative study. Psychology in the Schools 31, 113-119.

Rosenfield, S. (1992). Developing school-based consultation teams: A design for organizational change. School Psychology Quarterly, 7, 27-46.

Rosenfield, S. A., & Gravois, T. A. (1996). Instructional consultation teams: Collaborating for change. New York: The Guilford Press.

Rotheram-Borus, M. J. (1988). Assertiveness training with children. In R. H. Price, E. L. Cowen, R. P. Lorion, & J. Ramos-McKay (Eds.), 14 ounces of prevention: A casebook for practitioners, (pp. 83-97). Washington, DC: American Psychological Association.

Saigh, P. A., Green, B. L., & Korol, M. (1996). The history and prevalence of post-traumatic stress disorder with special reference to children and adolescents. Journal of School Psychology, 34(2), 107-131.

Sandoval, J. (1985). Crisis counseling: Conceptualizations and general principles. School Psychology Review, 14(3), 257-265.

Sandoval, J., & Brock, S. E. (1996). The school psychologist's role in suicide prevention. School Psychology Quarterly, 11(2), 169-185.

Schensul, J. J. (1994). Teen Action Research Project. Hartford, CT: Institute for Community Research.

Schensul, J. J., & Schensul, S. L. (1992). Collaborative research: Methods of inquiry for social change. In M. D., LeCompte, W. L. Millroy, & J. Preissle (Eds). The handbook of qualitative research in education (pp. 161-200). San Diego, CA: Academic.

Schensul, J. J. (1985). Systems consistency in field research, dissemination, and social change. American Behavioral Scientist, 29(2), 186-204.

Schensul, S. L. (1985). Science, theory, and application in anthropology. American Behavioral Scientist, 29(2), 164-185.

Shaffer, D., Garland, A., Vieland, V., Underwood, M., & Busner, C. (1991). The impact of curriculum-based suicide prevention programs for teenagers. Journal of the American Academy of Child and Adolescent Psychiatry, 30(4), 588-596.

Sheridan, S. M., Kratochwill, T. R., & Bergan, J. R. (1996). Conjoint behavioral consultation. New York: Plenum Press.

Short, R. J., & Rosenthal, S. L. (1995). Expanding roles or evolving identity? Doctoral school psychologists in school vs. nonschool practice settings. Psychology in the Schools, 32, 296-305.

Shrumpf, F., Crawford, D., & Usadel, H. C. (1991). Peer mediation: Conflict resolution in the schools. Champaign, IL: Research Press.

Shure, M. B., & Spivack, G. (1988). Interpersonal cognitive problem solving. In R. H. Price, E. L. Cowen, R. P. Lorion, & J. Ramos-McKay (Eds.), 14 ounces of prevention: A casebook for practitioners, (pp. 69-82). Washington, DC: American Psychological Association.

Silver, S. E., Duchnowski, A. J., Kutash, K., Friedman, R. M., Eisen, Prange, Brandenbuerg, & Greenbaum. (1992). A comparison of children with serious emotional disturbance served in residential settings. Journal of Child and Family Studies, 1(1), 43-59.

Sorenson, J. R. (1989). Responding to student or teacher death: Preplanning crisis intervention. Journal of Counseling and Development, 67, 426-427.

Soriano, M., Soriano, F. I., & Jimenez, E. (1994). School violence among culturally diverse populations: Sociocultural and institutional considerations. School Psychology Review, 23(2), 216-235.

Spirito, A., Overholster, J., Ashworth, S., Morgan, J., & Benedict-Drew, C. (1988). Evaluation of a suicide awareness curriculum for high school students. Journal of the American Academy of Child and Adolescent Psychiatry, 27(6), 705-711.

Spivack, G., & Shure, M. (1974). Social adjustment of young children: A cognitive approach to solving real-life problems. San Francisco: Jossey-Bass.

Stark, K. D., Brookman, C. S., & Frazier, R. (1990). A comprehensive school-based treatment program for depressed children. School Psychology Quarterly, 5, 111-140.

Stephens, R. D. (1994). Planning for safer and better schools: School violence prevention and intervention strategies. School Psychology Review, 23(2), 204-215.

Stolberg, A., Camplair, C., Curnier, K., & Wells, M. J. (1987). Individual, familial, and environmental determinants of children's post-divorce adjustment and maladjustment. Journal of Divorce, 11(1), 51-70.

Stolberg, A. L., & Garrison, K. M. (1985). Evaluating a primary prevention program for children of divorce. American Journal of Community Psychology, 13(2), 111-124.

Talley, R. C. & Short, R. J. (1996). Social reforms and the future of school practice: Implications for American psychology. Professional Psychology: Research and Practice, 27, 5-13.

Tharinger, D. (1995). Role for psychologists in emerging models of school-related health and mental health services. School Psychology Quarterly, 10 (3), 203-216.

Thompson, R. A. (1995). Being prepared for suicide or sudden death in schools: Strategies to restore equilibrium. Journal of Mental Health Counseling, 17(3), 264-267.

Tierney, R., Ramsay, R., & Tanney, B. (1990). Comprehensive school suicide prevention programs. Death Studies, 14, 347-370.

Tobler, N. S. (1986). Meta-analysis of 143 adolescent drug prevention programs: Quantitative outcome results of program participants compared to a control or comparison group. Journal of Drug Issues, 16, 537-567.

Tutty, L. M. (1992). The ability of elementary school children to learn child sexual abuse prevention concepts. Child Abuse and Neglect, 16, 369-384.

Weinberg, R. B. (1990). Serving large numbers of adolescent victim-survivors: Group interventions following trauma at school. Professional Psychology: Research and Practice, 21(4), 271-278.

Weissberg, R. P., Caplan, M., & Harwood, R., L. (1991). Promoting competent young people in competence-enhancing environments: A systems-based perspective on primary prevention. Journal of Consulting and Clinical Psychology, 59(6), 830-841.

Weissberg, R. P., & Gesten, E. L. (1982). Considerations for developing effective school-based social problem-solving (SPS) training programs. School Psychology Review, 11(1), 56-63.

Wurtele, S. K., Kast, L. C., Miller-Perrin, C.L., & Kondrick, P. A. (1989). Comparison of programs for teaching personal safety skills to preschoolers. Journal of Consulting and Clinical Psychology, 57(4), 505-511.

Wurtele, S. K., Saslawsky, D. A., Miller, C. L., Mars, S. R., & Britcher, J. C. (1986). Teaching personal safety skills for potential prevention of sexual abuse: A comparison of treatments. Journal of Consulting and Clinical Psychology, 54(5), 688-692.

Zill, N., & Schoenborn, C. A. (1990). Developmental, learning, and emotional problems: Health of our nations children, United States, 1988. Advanced Data: National Center for Health Statistics, Number 190 (November).

Zins, J. E., Travis, L., Brown, M., & Knighton, A. (1994). Schools and prevention of interpersonal violence: Mobilizing and coordinating community resources. Special Services in the Schools, 8(2), 1-19.

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